

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11965158</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/17/2019</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**ROSECASTLE AT DELANEY CREEK**

**320 S LAKEWOOD DRIVE  
BRANDON, FL 33511**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
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| CZ816<br>SS=C            | <p>408.809(2)(a-c); 59A-35.090(2)(d)-(3)<br/>Background Screening-Compliance Attestation</p> <p>408.809<br/>(2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's _____ to the Federal Bureau of Investigation for a national criminal history record check unless the person's _____ are enrolled in the Federal Bureau of Investigation's national retained print notification program. If the _____ of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit _____ electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the _____ to the Federal Bureau of Investigation for a national criminal history record check. The _____ shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person _____. Until a specified agency is fully implemented in the clearinghouse created under s. 435.12, the agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within _____</p> | CZ816               |                                                                                                                          |                          |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11965158</b>             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/17/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ROSECASTLE AT DELANEY CREEK</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>320 S LAKEWOOD DRIVE<br/>BRANDON, FL 33511</b> |                                                                                                                          |                                                        |
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| CZ816                                                                  | <p>Continued From page 1</p> <p>the previous 5 years to meet any provider or professional licensure requirements of the agency, the Department of Health, the Department of Elderly Affairs, the Agency for Persons with _____, the Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that:</p> <p>(a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section;</p> <p>(b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and</p> <p>(c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency.</p> <p>59A-35.090(2) Processing Screening Requests, Required Documents and Fees.</p> <p>(d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, _____, herein incorporated by reference, available at <a href="http://www.flrules.org/Gateway/reference.asp?No=Ref-09106">http://www.flrules.org/Gateway/reference.asp?No=Ref-09106</a>, and available from the Agency for Health Care Administration at: <a href="http://ahca.myflorida.com/MCHQ/Central_Service/s/Background_Screening/Regulations_Forms.shtml">http://ahca.myflorida.com/MCHQ/Central_Service/s/Background_Screening/Regulations_Forms.shtml</a>. This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if _____ for any</p> | CZ816                                                                                      |                                                                                                                          |                                                        |

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**ROSECASTLE AT DELANEY CREEK**

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| CZ816                    | <p>Continued From page 2</p> <p>disqualifying offense.</p> <p>(e) An administrator or chief financial officer must be screened and qualified prior to _____ to the position.</p> <p>(3) Results of Screening and Notification.</p> <p>(a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: <a href="https://apps.ahca.myflorida.com/SingleSignOnPortal">apps.ahca.myflorida.com/SingleSignOnPortal</a>.</p> <p>(b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the _____ report and court disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with section 435.06(3), F.S.</p> <p>(c) The eligibility results of employee screening and the signed Attestation referenced in subsection 59A-35.090(2), F.A.C., must be in the employee's personnel file, maintained by the provider.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide proof that employees completed an affidavit of compliance with background screening requirements (Compliance Affidavit) for two (Staff A and Staff C) of four employee records reviewed.</p> | CZ816               |                                                                                                                          |                          |

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| CZ816                    | Continued From page 3<br><br>Findings included:<br><br>A review of employee records conducted on _____ showed that Staff A was hired on _____ and Staff C was hired on _____. The review of both employee's record revealed an absence of page 4 of 4 on the Compliance Affidavit form (signature page with date of signature).<br><br>An interview was conducted with the business office manager (BOM) at 3:30 PM on _____ concerning the lack of page 4 of 4 on the Compliance Affidavit form in the employee's record. The BOM reviewed both employee's records and stated the Compliance Affidavit form was not there.<br><br>Unclassified | CZ816               |                                                                                                                          |                          |
| A 000                    | Initial Comments<br><br>A biennial survey with extended congregate care (ECC) was conducted at Rosecastle at Delaney Creek on _____. Deficiencies were identified at the time of survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                        | A 000               |                                                                                                                          |                          |
| A 078<br>SS=D            | 59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF.<br>(a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable _____. The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without                                                                                                                                              | A 078               |                                                                                                                          |                          |

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| A 078                    | <p>Continued From page 4</p> <p>a break in service from one facility to another when the facility is under the same management or ownership.</p> <p>1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of . . . . . testing materials satisfies the annual . . . . . examination requirement. An individual with a positive . . . . . test must submit a health care provider's statement that the individual does not constitute a risk of . . . . .</p> <p>2. If any staff member has, or is suspected of having, a communicable . . . . ., such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . . . . .</p> <p>(b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter.</p> <p>(c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C.</p> <p>(d) An assisted living facility . . . . . to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with</p> | A 078               |                                                                                                                          |                          |

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| A 078                    | <p>Continued From page 5</p> <p>this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents.</p> <p>(e) For facilities with a licensed capacity of 17 or more residents, the facility must:</p> <ol style="list-style-type: none"> <li>1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and,</li> <li>2. Maintain time sheets for all staff.</li> </ol> <p>(f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that staff had a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . . . . . for 1 (Staff C) out of 4 sampled.</p> <p>Findings include:</p> <p>A review of employee record conducted on . . . . . revealed Staff C was hired on . . . . . and there was no that statement from a health care provider indicating Staff C was free from communicable . . . . . in the file.</p> <p>An interview was conducted with the Business Office Manager (BOM) at 3:30 PM on . . . . . the BOM reviewed Staff C's record and agreed a written statement from a health care provider stating Staff C was free from communicable . . . . . was not there.</p> <p>Class III</p> | A 078               |                                                                                                                          |                          |

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| A 082                    | Continued From page 6                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | A 082               |                                                                                                                          |                          |
| A 082<br>SS=D            | <p>59A-36.011(4) FAC Training - /</p> <p>(4)</p> <p>Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on and , including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide proof that 2 (Staff A and Staff C) of 4 employees completed a one-time education course on ( ) and acquired ( ) within 30 days of employment.</p> <p>Findings included:</p> <p>A review of employee records conducted on , revealed that Staff A, hired on and Staff C, hired on , did not have the required and training in their employee record.</p> <p>An interview was conducted with the Business Office Manager (BOM) at 3:30 PM on concerning the lack of documentation of the and training. The BOM reviewed both employee's records and stated that the and training documentation was not there.</p> | A 082               |                                                                                                                          |                          |

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| A 082                    | Continued From page 7<br><br>Class III                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | A 082               |                                                                                                                          |                          |
| A 162<br>SS=D            | 59A-36.015(3) FAC Records - Resident<br><br>(3) RESIDENT RECORDS. Resident records must be maintained on the premises and include:<br>(a) Resident demographic data as follows:<br>1. Name,<br>2. ,<br>3. Race,<br>4. Date of birth,<br>5. Place of birth, if known,<br>6. Social security number,<br>7. Medicaid and/or Medicare number, or name of other health insurance ,<br>8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and,<br>9. Name, address, and telephone number of the health care provider and case manager, if applicable.<br>(b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C.<br>(c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order.<br>(d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable.<br>(e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C.<br>(f) A record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily | A 162               |                                                                                                                          |                          |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ROSECASTLE AT DELANEY CREEK</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>320 S LAKEWOOD DRIVE<br/>BRANDON, FL 33511</b>                               |  |                                                        |
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| A 162                                                                  | Continued From page 8<br><br>living must have their _____ recorded<br>semi-annually.<br>(g) For facilities that will have unlicensed staff<br>assisting the resident with the self-administration<br>of medication, a copy of the written informed<br>consent described in rule 59A-36.006, F.A.C., if<br>such consent is not included in the resident's<br>contract.<br>(h) For facilities that manage a pill organizer,<br>assist with self-administration of medications or<br>administer medications for a resident, copies of<br>the required medication records maintained<br>pursuant to rule 59A-36.008, F.A.C.<br>(i) A copy of the resident's contract with the<br>facility, including any addendums to the contract<br>as described in rule 59A-36.018, F.A.C.<br>(j) For a facility whose owner, administrator, staff,<br>or representative thereof, serves as an attorney in<br>fact for a resident, a copy of the monthly written<br>statement of any transaction made on behalf of<br>the resident as required in section 429.27, F.S.<br>(k) For any facility that maintains a separate trust<br>fund to receive funds or other property belonging<br>to or due a resident, a copy of the quarterly<br>written statement of funds or other property<br>disbursed as required in section 429.27, F.S.<br>(l) If the resident is an _____ recipient, a copy of<br>the Department of Children and Families form<br>Alternate Care Certification for _____<br>_____, (_____), CF-ES 1006,<br>_____, which is hereby incorporated by reference<br>and available for review at:<br><a href="http://www.flrules.org/Gateway/reference.asp?No=Ref-04004">http://www.flrules.org/Gateway/reference.asp?No=Ref-04004</a> . The absence of this form will not be<br>the basis for administrative action against a<br>facility if the facility can demonstrate that it has<br>made a good faith effort to obtain the required<br>documentation from the Department of Children<br>and Families. | A 162                                                                          |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11965158</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/17/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ROSECASTLE AT DELANEY CREEK</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>320 S LAKEWOOD DRIVE<br/>BRANDON, FL 33511</b>                               |  |                                                        |
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| A 162                                                                  | <p>Continued From page 9</p> <p>(m) Documentation of the _____ of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable.</p> <p>(n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C.</p> <p>(o) The resident's _____, DH Form 1896, if applicable.</p> <p>(p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility:</p> <ol style="list-style-type: none"> <li>1. A log listing the names of residents participating in this arrangement,</li> <li>2. The resident demographic data required in this paragraph,</li> <li>3. The health assessment described in rule 59A-36.006, F.A.C.,</li> <li>4. The resident's contract described in rule 59A-36.018, F.A.C.; and,</li> <li>5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility.</li> </ol> <p>(q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility.</p> <p>(r) Additional resident records requirements for facilities holding a limited mental health, extended</p> | A 162                                                                          |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**ROSECASTLE AT DELANEY CREEK**

**320 S LAKEWOOD DRIVE  
BRANDON, FL 33511**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
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| A 162                    | <p>Continued From page 10</p> <p>congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively.</p> <p>This Statute or Rule is not met as evidenced by: Based on records review and interview, the facility failed to maintain a copy a Resident Health Assessment form (AHCA form 1823), identifying any health related problems, for 1 of 2 residents (Resident #6).</p> <p>Findings Included:</p> <p>A review of Resident #6's record was conducted on _____. Prior to the record review, in an interview with the Director of Nursing (DON) at around 11:30am on _____, she told AHCA that the facility had recently uploaded all medical records in an electronic format and destroyed all paper copies of the records. The DON told AHCA that the records were available for review, however AHCA would have to request which elements of the resident's records they needed to look at and the facility would print them out. AHCA requested 2 resident's records, including the original and most recent AHCA form 1823 assessments.</p> <p>The requested records were received and Resident #6's record revealed the most recent AHCA form 1823, dated _____, had information that was unclear and not easily understood. Under the portion of Section 1 - Health Assessment, entitled "Medical History and Diagnoses (please list)", the following was written: F32.89, K21.9, R25.1, 795.0, I50.0, M62.81 and F03.90. Photographic evidence obtained.</p> <p>In an interview with the DON later that afternoon</p> | A 162               |                                                                                                                          |                          |

Agency for Health Care Administration

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|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 162                    | Continued From page 11<br><br>at 1:15pm, AHCA requested more information regarding Resident #6's actual medical history and diagnoses. The DON replied that it was written on the resident's sheet and offered to print out the sheet. AHCA declined to review the sheet in lieu of the most current 1823, as it should be the most complete and up to date information and sheets did not have the same requirement. The medical information requested, for Resident #6, which would have been the meaning of the codes written on the AHCA form 1823, was never provided.<br><br>Class III | A 162               |                                                                                                                          |                          |