Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965503	A. BUILDING: _____ B. WING _____	12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESIDENTIAL PLACE	3880 SOUTH CIRCLE DRIVE HOLLYWOOD, FL 33021

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CZ816	408.809(2)(a-c); 59A-35.090(2)(d)-(3) Background Screening-Compliance Attestation 408.809 (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	CZ816		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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CZ816	Continued From page 1 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: (a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section; (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 (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. 59A-35.090(2) Processing Screening Requests, Required Documents and Fees. (d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, , herein incorporated by reference, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-09106, and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Regulations_Forms.shtml. 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	CZ816		

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CZ816	Continued From page 2 disqualifying offense. (e) An administrator or chief financial officer must be screened and qualified prior to . , , ... to the position. (3) Results of Screening and Notification. (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: apps.ahca.myflorida.com/SingleSignOnPortal. (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. (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. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all staff have an attestation form 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,	CZ816		

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CZ816	Continued From page 3 and they agree to inform the employer immediately if for any disqualifying offense for 1 of 4 sampled employee records. (Specifically, Staff C). The findings included: On a review of the employee personnel records was conducted. It was revealed that the level II background screening attestation form was missing from the employee personnel file for Staff C. Staff C was hired on . She works as a Certified Nursing Assistant (CNA). She provides direct resident care. On at 04:30 PM, an interview was conducted with the Administrator. He acknowledged the findings. Unclassified	CZ816		

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A 000	Initial Comments An unannounced Change of Ownership (CHOW) survey and a licensure complaint survey, #2019013907 & #2019015291, was conducted on [redacted] through [redacted] at Presidential Place, an Assisted Living Facility. The facility had deficiencies at the time of the survey.	A 000		
A 010 SS=D	429.26(.&9) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination shall be based upon an assessment of the strengths, needs, and preferences of the resident, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (2) A physician, physician assistant, or nurse practitioner who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interest in the facility.	A 010		

AHCA Form 3020-0001

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A 010	Continued From page 1 (9) A [illegible] ill resident who no longer meets the criteria for continued residency may remain in the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident are being met. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 59A-36.002, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days. (b) A resident requiring care of a [illegible] may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within	A 010		

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A 010	Continued From page 2 30 days, as documented by a health care provider, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in rule 59A-36.021, F.A.C.	A 010		

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A 010	Continued From page 3 This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to assess residents for continued residency based on a significant changes for 1 of 6 sampled residents. (Specifically, Resident # 2). The findings included: On . . . . at 12:05 PM, an observation was made of Resident # 2. She came into the conference room. She was crying. She stated someone is supposed to meet her about her money. She says the Administrator should have given her the money last week. She says she could not remember her room number. She asked who was the person in charge. She stated she did not know why the Administrator kept her money. She came to the conference room at 3:00 PM, and began to complain again. She says he took everything away from her. She stated she was suffering. She was tearful. She was . She was observed pacing and forth in front of the receptionist desk talking to herself. On at 03:00 PM, an interview was conducted with the Regional Wellness Director. She was asked about the allegations made by Resident # 2. She admitted that the Resident had been recently. She stated she did not have a new care plan nor a new Florida Health Assessment (AHCA 1823 form) to determine continued residency. A review of the medical record was conducted for Resident # 2. Resident # 2 was admitted on . A review of the AHCA 1823 form revealed a date of . She suffers from	A 010		

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A 010	Continued From page 4 , and . She is independent with all of her Activities of Daily Living (ADL's). The section regarding or behavioral status indicates . The section on the AHCA 1823 form regarding Special Precautions is left blank. The section under elopement risk has both yes and no marked. A review of the progress notes reveal on , Resident # 2 was overheard stating that she wanted to kill herself. She was as observed walking toward the nearest main street to the facility. She was redirected to the community. She was then that day. It is unknown what date the resident returned to the facility, as the next progress note is dated . On at 04:00 PM, an interview was conducted with the Administrator, Regional Wellness Director and Director of Nursing. They acknowledged the findings. Class III Based on record review and interview, the facility failed to ensure resident Agency for Healthcare Administration Health Assessment (AHCA Form 1823) was updated after a significant change and reflective of current care needs, for 1 of 3 sampled residents (Resident#11). The Findings Included: Resident#11's AHCA form 1823 dated was reviewed and revealed the	A 010		

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A 010	Continued From page 5 resident has a medical history of [redacted] Type II, [redacted], and 4 [redacted]. Further review of the AHCA Form 1823 revealed the resident requires assistance with self administration of medication. Review of Resident#11's physician orders dated [redacted], home health was ordered for [redacted] evaluation and treatment. On [redacted], a new physician order was written for home health to perform daily [redacted] monitoring and [redacted] administration. At this time there was no updated AHCA Form provided. On [redacted] at approximately 4:30 PM, during an interview with the Administrator and Health and Wellness Director, acknowledged the findings and provided no additional documentation for review. Class III	A 010		
A 026 SS=D	59A-36.007(2) FAC Resident Care - Social & Leisure Activities (2) SOCIAL AND LEISURE ACTIVITIES. Residents shall be encouraged to participate in social, recreational, educational and other activities within the facility and the community. (a) The facility must provide an ongoing activities program. The program must provide diversified individual and group activities in keeping with each resident's needs, abilities, and interests. (b) The facility must consult with the residents in selecting, planning, and scheduling activities. The facility must demonstrate residents' participation through one or more of the following methods: resident meetings, committees, a resident council, a monitored suggestion box, group discussions, questionnaires, or any other form of	A 026		

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A 026	Continued From page 6 communication appropriate to the size of the facility. (c) Scheduled activities must be available at least 6 days a week for a total of not less than 12 hours per week. Watching television is not an activity for the purpose of meeting the 12 hours per week of scheduled activities unless the television program is a special one-time event of special interest to residents of the facility. A facility whose residents choose to attend day programs conducted at adult day care centers, senior centers, mental health centers, or other day programs may count those attendance hours towards the required 12 hours per week of scheduled activities. An activities calendar must be posted in common areas where residents normally congregate. (d) If residents assist in planning a special activity such as an outing, seasonal festivity, or an excursion, up to 3 hours may be counted toward the required activity time. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide an ongoing activities program. The program must provide diversified individual and group activities in keeping with each resident's needs, abilities, and interests for residents in the Memory Care Units of the facility. The findings included: On at 09:15 AM, an observation was made of residents in Memory Care Unit II. It was revealed that residents were sitting in the dining room area. There was one staff member present. On at 09:30 AM, an interview was	A 026		

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A 026	Continued From page 7 conducted with Staff D. She stated she usually works alone on the 07:00 AM - 03:00 PM shaft. She says she does not have time to conduct group activities. On at 10:30 AM, an interview was conducted with the Activities Director. She stated that she provided activities for the general assisted living. She stated the Aides were responsible for Activities for the Memory Care Units. On at 12:00 PM, an interview was conducted with the Supervisor of Memory Care. She was asked about the activity schedule for the Memory Care Units. She stated she was only hired a week ago. She stated that she will receive training in a week to conduct activities for the Memory Care Units. On at 12:30 PM, an interview was conducted with a Family Member of Resident # 12. She stated that she visits daily. She stated they do not have any group activities in Memory Care II, because they don't have enough staff. On and , random observations were made of the Memory Care Units I and II. The residents were never seen participating in activities. On at 04:30 PM, an interview was conducted with the Administrator. He acknowledged the findings. Class III	A 026		
A 031 SS=D	59A-36.007(7) FAC Resident Care - Third Party Services 59A-36.007	A 031		

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A 031	Continued From page 8 (7) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, , and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the , resident's needs. (c) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility	A 031		

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A 031	Continued From page 9 failed to ensure Third Party Services documentation was maintained to ensure coordination, collaboration, and facilitation of care and service were being provided, for 1 of 3 sampled residents (Resident#11). The Findings Included: On at 10:00 AM during the observational tour, this surveyor was informed that Resident#11 received home health for . During a record review for this resident, it was revealed Resident#11 receives home health for , daily monitoring, and administration. At this time, the residents physician orders were reviewed and revealed a physician order for on and and a new order for monitoring, and administration on . The progress notes for Resident#11 were reviewed and revealed no documentation or indicator in the resident file that home heath service had been coordinated or was being provided. The home health documentation was requested from the Health and Wellness Director (HWD), and she was unable to provided the documentation. At this time, the facility was provided an opportunity to locate the documentation. . A review of the facility Third Party Service policy and procedures were revived and documented the third party service authorize the release of resident records to the community for the collaboration and facilitation of care and services. The HWD requested and received the documentation from the home health agency. During an interview with the Administrator, and HWD on at approximately 4:30 PM,	A 031		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 031	Continued From page 10 they acknowledged the findings, and provided no additional documentation for review. Class III	A 031		
A 032 SS=D	59A-36.007(8) FAC Resident Care - Elopement Standards 59A-36.007 (8) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all	A 032		

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	AL11965503	A. BUILDING: _____ B. WING _____	12/05/2019

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A 032	Continued From page 11 facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to sections 429.41(1)(a)3. and 429.41(1)(i), F.S. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to conduct and document resident elopement drills for all direct care staff and administration, at a minimum twice a year. The findings included:	A 032		

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A 032	Continued From page 12 On [redacted] a review of the facility elopement drill in-service sign in log was conducted. It was revealed that the facility did not conduct mock drills in 2018/2019 for all of their direct care staff and administrators. A review of the employee in-service log for mock drills revealed that elopement drills were conducted on the following dates: a) [redacted] - 30 staff members b) [redacted] - 6 staff members c) [redacted] - 4 staff members d) [redacted] - 4 staff members A review of the employee staff roster reveal the facility has 38 direct care staff. The facility has 8 administrative staff employed. On [redacted] at 04:30 PM, an interview was conducted with the Administrator. He acknowledged the findings. Class III	A 032		
A 057 SS=D	59A-36.008(8) FAC Medication - Over The Counter (OTC) Products (8) OVER THE COUNTER (OTC) PRODUCTS. For purposes of this subsection, the term over the counter includes, but is not limited to, over the counter medications, [redacted], nutritional supplements and nutraceuticals, hereafter referred to as OTC products, that can be sold without a prescription. (a) A facility may keep a stock supply of OTC products for multiple resident use. When providing any OTC product that is kept by the facility as a stock supply to a resident, the staff member providing the medication must record	A 057		

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A 057	Continued From page 13 the name and amount of the OTC product provided in the resident's medication observation record. All OTC products kept as a stock supply must be stored in a locked container or secure room in a central location within the facility and must be labeled with the medication's name, the date of purchase, and with a notice that the medication is part of the facility's stock supply. (b) OTC products, including those prescribed by a health care provider but excluding those kept as a stock supply by the facility, must be labeled with the resident's name and the manufacturer's label with directions for use, or the health care provider's directions for use. No other labeling requirements are required. (c) Residents or their representatives may purchase OTC products from an establishment of their choice. (d) A health care provider's order is required when a nurse provides assistance with self-administration or administration of OTC products. When an order for an OTC product exists, the order must meet the requirements of paragraphs (b) and (c) of this subsection. A health care provider's order for OTC products is not required when a resident self-administers his or her medications, or when unlicensed staff provides assistance with self-administration of medications. This Statute or Rule is not met as evidenced by: Based on record review, observation, and interview, the facility failed to ensure a health care providers order was obtained for over the counter medication for 1 of 3 sampled residents (Resident#11). The Findings Included: On at approximately 10:00 AM during	A 057		

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A 057	Continued From page 14 the observation tour the following over the counter medications were observed: in the residents room: 1 box Mix in Pax (20 Count), Relief Syrup, for Tablets (2 Bottles 200 count each), Refresh Optive , , Flintstone . The resident has a family who assist in her care, who stated she will contact the resident's son to ask if it is ok to give the resident the medication. At this time, during an interview with the Health and Wellness Director who stated over the counter medication should not be kept in the resident room, and was not aware of the medication being in the residents room. The facility Over the Counter policy documents resident who receive assistance with self-administration of medication are not permitted to have over the counter medications their rooms, and all over the counter medications must be approved by a physician and prescription must be obtained. On at approximately 4:30 PM, drug an interview with the Administrator and HWD acknowledged the findings. Class III	A 057		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (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	A 078		

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A 078	Continued From page 15 does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 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 . . . . . . 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 . (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. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility . . . . . to provide services to residents must ensure that individuals providing services are qualified to	A 078		

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A 078	Continued From page 16 perform their assigned duties in accordance with 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. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (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. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure all staff received 3 hours of Activity of Daily Living and Behavioral Needs training for 1 of 4 sampled staff (Staff A). The Findings Included: On . . . . . at approximately 10:00 AM, a employee record review was conducted for Staff A whose hire date was . . . . . . Further review revealed a certificate of completion for hour of ADL and Behavioral Needs Training. dated . At this time the facility was provided an opportunity to locate additional documentation. During an interview with the Administrator and the Health and Wellness Director, they acknowledged the findings and proved no additional documentation for review. Class III	A 078		

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A 081	Continued From page 17	A 081		
A 081 SS=D	59A-36.011( ) FAC Training - Staff In-Service (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement.	A 081		

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A 081	Continued From page 18 (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident . . . . . , neglect, and , . The facility must use its . . prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures.	A 081		

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A 081	Continued From page 19 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide in-service training to direct care staff who provide direct care service to residents, for 2 of 4 sampled staff employee records reviewed (Staff A and C). The findings included: a) On . . . . . a review of the employees records was conducted. Staff C was hired on . . . . . to provide direct care to residents. A review of the employee personnel file revealed that the training certificate for Activities of Daily Living (ADL's) revealed that the certificate displayed one (1) hour, instead of the required three (3) hours required. A review of the training certificate for Elopement training for Staff C revealed that there was only .50 (half hour), instead of the 1 hour required. b) On . . . . . at approximately 10:00 AM, a employee record review was conducted for Staff A, whose hire date was . . . . . Further review revealed a certificate of completion for dated . . . . . , for . hour of the facility Elopement policy and procedures. At this time a review of the facility Elopement Drills were requested and revealed the elopement drills did not document facility wide training. At this time the facility was provided an opportunity to locate additional documentation. On . . . . . at approximately 4:30 PM, during an interview with the Administrator and the Health	A 081		

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A 081	Continued From page 20 and Wellness Director, they acknowledged the fining's, and provided no additional documentation for review. Class III	A 081		
A 087 SS=D	58A-5.0194 FAC . . . . . Training - Prov & Curriculum Appr (1) The or Related ("ADRD") training provider and curriculum must be approved by the department or its designee before commencing training activities. The department or its designee will maintain a list of approved ADRD training providers and curricula, which may be obtained from http://usfweb3.usf.edu/trainingonAging/default.aspx. (a) ADRD Training Providers. 1. Individuals who seek to become an ADRD training provider must provide the department or its designee with the documentation of the following educational, teaching, or practical experience: a. A Master's degree from an accredited college or university in a health care, human service, or . . . . . related field; or b. A Bachelor's degree from an accredited college or university, or licensure as a registered nurse, and: (I) Proof of 1 year of teaching experience as an educator of caregivers for individuals with . . . . . or related . . . . . ; or (II) Proof of completion of a specialized training program specifically relating to . . . . . 's or related , and a minimum of 2 years of practical experience in a program providing direct care to individuals with . . . . . or related . . . . . ; or	A 087		

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A 087	Continued From page 21 (III) Proof of 3 years of practical experience in a program providing direct care to persons with or related . c. Teaching experience pertaining to 's or related may substitute on a year-by-year basis for the required Bachelor's degree. 2. Applicants seeking approval as ADRD training providers must complete DOEA form ALF/ADRD-001, Application for 's or Related Training Provider Certification, dated , which is incorporated by reference and available at the Department of Elder Affairs, 4040 Esplanade Way, Tallahassee, Florida 32399-7000 and online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04000. (b) ADRD Training Curricula. Applicants seeking approval of ADRD curricula must complete DOEA form ALF/ADRD-002, Application for 's or Related Training Three-Year Curriculum Certification, dated , which is incorporated by reference and available at the Department of Elder Affairs, 4040 Esplanade Way, Tallahassee, Florida 32399-7000 and online at http://www.flrules.org/Gateway/reference.asp?No=Ref-04001. Approval of the curriculum will be granted based on how well the curriculum addresses the subject areas referenced in subparagraphs 58A-5.0191(4)(a)2. and 58A-5.0191(4)(a)5., F.A.C. Curriculum approval will be granted for 3 years. After 3 years the curriculum must be resubmitted to the department or its designee for approval. (2) Approved ADRD training providers must maintain records of each course taught for a period of 3 years following each training	A 087		

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A 087	Continued From page 22 presentation. Course records must include the title of the approved ADRD training curriculum, the curriculum approval number, the number of hours of training, the training provider ' s name and approval number, the date and location of the course, and a roster of trainees. (3) Upon successful completion of training, the trainee must be issued a certificate by the approved training provider. The certificate must include the trainee's name, the title of the approved ADRD training, the curriculum approval number, the number of hours of training received, the date and location of the course, the training provider's name and approval number, and dated signature. (4) The department or its designee reserves the right to attend and monitor ADRD training courses, review records and course materials approved pursuant to this rule, and revoke approval for the following reasons: non-adherence to approved curriculum, failing to maintain required training credentials, or knowingly disseminating any false or misleading information. (5) ADRD training providers satisfying the requirements of Section 400.1755, F.S., relating to nursing homes, and Section 400.6045, F.S., relating to hospices, will satisfy the Level 1 and Level 2 training provider requirements of subparagraph 58A-5.0191(4)(a)3. and paragraph 58A-5.0191(4)(a), subsection (5), F.A.C. ADRD training curricula satisfying the requirements of Section 400.1755, F.S., relating to nursing homes, and Section 400.6045, F.S., relating to hospices, will satisfy the Level 1 curriculum requirements of subparagraph 58A-5.0191(4)(a)3., F.A.C. This Statute or Rule is not met as evidenced by: Based on record review an interview, the facility	A 087		

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A 087	Continued From page 23 failed to ensure that all staff received the required 4 Level I and II training for 1 of 4 sampled staff Staff B, the facility also failed to ensure the Trainer was a Department of Elder Affairs (DOE) approved trainer and curriculum for 1 of 4 sampled staff (Staff A). The Findings Included: On at approximately 10:30 AM, a employee record review was conducted for Staff B whose hire date was . Further review revealed Staff B whose hire date was , had no certificate of completion for 4 hours of Level I and II training. At this time, Staff A's 4 hour I and II certificate of completion dated and was reviewed and revealed no documentation that verified the trainer was a Department of Elder Affairs approved trainer and that the DOE curriculum was used. At this time the facility was provided an opportunity to provide the verification, no further documentation provided. On at approximately 4:30 PM, during an interview with the Administrator and the Health and Weliness Director, they acknowledged the the findings and provided no additional documentation for review. Class III	A 087		
A 090 SS=D	59A-36.011(11) FAC Training - (11) TRAINING. (a) Currently employed facility administrators,	A 090		

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	AL11965503	A. BUILDING: _____ B. WING _____	12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESIDENTIAL PLACE	3880 SOUTH CIRCLE DRIVE HOLLYWOOD, FL 33021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 090	Continued From page 24 managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding . (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding for 2 of 4 sampled staff. (Specifically, Staff A and Staff C). The findings included: a) On a review of the employee personnel file was conducted. It was revealed that Staff C was hired on . She provides direct care to residents of the facility. A review of the training certificate for reveals that the number of hours provided consisted of .75 instead of the required 1.00 hours. On at 04:30 PM, an interview was conducted with the Administrator. He acknowledged the findings. b) On at 10:00 AM, a employee record review was conducted for Staff A whose hire date was . Further review	A 090		

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A 090	Continued From page 25 revealed on a certificate of completion dated , for hour of training. At this time the facility was provided an opportunity to locate additional documentation. On at approximately 4:30 PM, during an interview with the Administrator and Health and Wellness Director, they acknowledged the findings and provided no additional documentation for review. Class III	A 090		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 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, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or	A 162		

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A 162	Continued From page 26 implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C. (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 living must have their ⌄ recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form	A 162		

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A 162	Continued From page 27 Alternate Care Certification for , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (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. (o) The resident's , DH Form 1896, if applicable. (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: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 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	A 162		

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A 162	Continued From page 28 facility. (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. (r) Additional resident records requirements for facilities holding a limited mental health, extended 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. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure ˬ were recorded twice a year for residents who receive assistance with Activities of Daily Living (ADL's) for 2 of 3 sampled residents (Resident#11 and Resident # 12). The Findings Included: On at approximately 3:00 PM, Resident#11's ˬ record was requested from the Health and Wellness Director.(HWD). A review of the resident record was condcucted and had no documentation of ˬ being recorded twice a year. Further review revealed the resident receives supervision or assistance with all ADL's. At this time the facility was provided an opportunity to locate the documentation. On at approximately 4:30 PM, during an interview with the Administrator and HWD, they acknowledged the findings and provided additional documentation for review.	A 162		

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A 162	Continued From page 29 On . . . . . a review of the Florida Health Assessment form (AHCA 1823 form) was conducted. It was revealed Resident # 12 was admitted into the facility on . The last medical exam for the AHCA 1823 form was dated . It was revealed that the bi-annual . . were not logged in the medical record. On . . . . . at 04:30 PM, an interview was conducted with the Administrator. He acknowledged the findings. Class III	A 162		