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
	AL11965589	A. BUILDING: _____ B. WING _____	R 09/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH COURT OF ST CLOUD	3791 OLD CANOE CREEK RD SAINT CLOUD, FL 34769

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CZ813 SS=C	59A-35.090(3)(c), FAC Results of Screening & Notification In File 59A-35.090(3) Results of Screening and Notification. (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 personnel record review and interview, the facility failed to maintain the Level 2 Background Screening eligibility results in the personnel file for 1 of 4 sampled staff (H). Findings: Review of the personnel record for staff H, caregiver, hired , did not reveal a Level 2 background screening result. Review of the Agency Background website found an eligibility date of . On at 3:10 PM, the administrator confirmed the finding. Unclassified	CZ813		
{CZ816} SS=C	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	{CZ816}		

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{CZ816}	Continued From page 1	{CZ816}		

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 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

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{CZ816}	Continued From page 2 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 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	{CZ816}		

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{CZ816}	Continued From page 3 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: DEFICIENCY REMAINED UNCORRECTED Based on record review and interview, the facility failed to ensure that 2 of 7 personnel records contained an Attestation of Compliance with Background Screening Requirements (C & G). Findings: 1. Personnel record for dietary manager G, hired . . . . . , did not contain evidence she completed an Attestation of Compliance with Background Screening Requirements, AHA Form 3100-0008,	{CZ816}		

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{CZ816}	Continued From page 4 On at 2:45 PM, the administrator confirmed the finding and said she was unable to locate the form. 2. Personnel record for caregiver C, hired , did not contain evidence he completed an Attestation of Compliance with Background Screening Requirements, AHA Form 3100-0008, . The AHCA form 3100-008 in the personnel record was blank. On at 2:45 PM, the administrator confirmed the findings. Unclassified	{CZ816}		
{A 000}	Initial Comments A revisit to the Relicensure survey was conducted on . Savannah Court of Saint Cloud had uncorrected deficiencies at the time of survey.	{A 000}		
{A 081} SS=D	58A-5.0191( ) 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	{A 081}		

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{A 081}	Continued From page 5 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 [illegible] control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its [illegible] control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to [illegible] borne [illegible], may be used to meet this requirement. (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 [illegible],	{A 081}		

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{A 081}	Continued From page 6 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. 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: DEFICIENCY REMAINED UNCORRECTED Based on personnel record review and interview, the facility failed to ensure that 4 of 7 staff completed a 2-hour preservice orientation prior to interacting with the residents (A, C, H & F), and failed to ensure 2 of 7 staff completed the required in-service training (E & H).	{A 081}		

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{A 081}	Continued From page 7 Findings: 1. Personnel record review for caregiver A, hired , revealed a certificate dated that indicated Part 1 orientation. The certificate did not indicate the preservice orientation which covered the facility's license type and services offered by the facility. There was no evidence she attended assisted living CORE training, therefore exempt from this requirement. 2. Personnel record review for caregiver C, hired , revealed a certificate dated that documented a 2-hour preservice orientation. The certificate did not indicate the preservice orientation which covered the facility's license type and services offered by the facility. There was no evidence she attended assisted living CORE training, therefore exempt from this requirement. 3. Personnel record review for staff F, hired and was observed on at 10AM performing housekeeping duties revealed no evidence she completed a 2-hour pre-service orientation prior to interacting with the residents. There was no evidence she attended assisted living CORE training, therefore exempt from this requirement. 4. Review of the personnel record for executive director E, who at times provided care to the facility residents, revealed a hire date of . The receord did not contain evidence that she completed a 1-hour control in-service training, and a 3-hour Activities of Daily Living and Resident Behavior and Needs in-service training. There was no evidence she was a licensed nurse, home health aide or a certified nursing assistant, therefore exempt from this	{A 081}		

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{A 081}	Continued From page 8 requirement. 5. Review of the personnel record for caregiver H, hired , found no evidence she completed the 2-hour preservice orientation prior to interacting with residents. There was no evidence she attended assisted living CORE training, therefore exempt from this requirement. The record did not contain evidence she completed a 1-hour control in-service training, and a 3-hour in-service training in Activities of Daily Living and Resident Behavior and Needs. There was no evidence she was a licensed nurse, home health aide or a certified nursing assistant, therefore exempt from this requirement. The record did not contain evidence to confirm she attended an in-service training regarding the facility's elopement policies and procedures, and a 1-hour in-service training in nutrition and safe food handling. On at 3:35 PM, the executive director confirmed the findings. Class III	{A 081}		
{A 082} SS=D	58A-5.0191(4) FAC Training - / (4) . . . . . / . . . . . (. / . . .). 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	{A 082}		

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{A 082}	Continued From page 9 maintained in accordance with subsection (12), of this rule. This Statute or Rule is not met as evidenced by: DEFICIENCY REMAINED UNCORRECTED Based on personnel record review and interview, the facility failed to ensure that 2 of 7 sampled staff had completed the required in-service training course on (/) within 30 days of hire (E & H). Findings: 1. Review of the personnel record for executive director E revealed a hire date of . The record did not contain evidence that she received received training in / . 2. Review of the personnel record for caregiver H, hired , did not find evidence of training in / . On at 3:35PM, the executive director confirmed the finding. Class III	{A 082}		
{A 093} SS=D	58A-5.020(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No	{A 093}		

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{A 093}	Continued From page 10	{A 093}		

=Ref-04003, and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are incorporated by reference and available for review at: http://iom.edu/Activities/Nutrition/SummaryDRIs/~/media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%2014.pdf. Therapeutic diets must meet these nutritional standards to the extent possible.
(b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes.
(c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet.
1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences.
2. Menu items may be substituted with items of comparable nutritional value based on the

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{A 093}	Continued From page 11	{A 093}		

seasonal availability of fresh produce or the preferences of the residents.
(d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months.
(e) Therapeutic diets must be prepared and served as ordered by the health care provider.
1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility.
2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal.
(f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of _____ the time between meals.
(g) Food must be served attractively at safe and

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{A 093}	Continued From page 12 palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on . . . . . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on . . . at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority This Statute or Rule is not met as evidenced by: DEFICIENCY REMAINED UNCORRECTED Based on observation, record review and interview, the facility failed to maintain a signed a dated menu approved by a licensed dietician, failed to maintain 6 months of menus served to the residents, failed to maintain 6 months of substitutions made to the menu, failed to maintain the dining room with clean linens on the tables, and failed to maintain a 3 day supply of water in the facility for use in the event of an emergency. Findings: Observation during a tour of the facility on . . . . revealed a paper menu posted at the entrance to the dining room for the current day's meals. Observations during the tour did not reveal a posting of dining hours.	{A 093}		

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{A 093}	Continued From page 13 1. On . . . . at 12 PM, the dietary manager provided the menu she stated she used for meal preparation. The menu had a print date of . . . . on the bottom. It was not signed by a dietician. The menu had the word "draft" printed diagonally across it over the meals. The manager had written in the current week's dates along the top. There was a 4-week rotation of the menu in the facility and she was using week 3 on . . . . . On . . . . at 12:10 PM, the dietary manager stated she did not have any other menu beside the draft menu she provided for review. She was unaware of a signed menu or who the dietician was for the facility. On . . . . at 3 PM, the executive director provided a copy of a different menu that she stated was signed. The menu did not have draft printed on it. It had a very faint, not legible stamp of a signature on the bottom left side of the menu. She provided week 3 of this menu. There was no date showing when the menu was approved by the dietician. The print date on the footer of the menu showed a . . , . . . date, but it was too blurry to be legible. The executive director stated she did not have any other documentation regarding the menu. 2. Documentation of menus for the previous 6 months was not maintained. On . . . . at 12:10 PM, the dietary manager stated she printed out daily sheets of paper with the day's meal on it and posted a copy on each side of the dining room. After the day is over, she throws the paper away. She stated she was not informed of the requirement to maintain menus for 6 months. There were documented substitutions on the menu for . . . . , but she was unable to provide documentation of the original menus for the	{A 093}		

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{A 093}	Continued From page 14 previous 6 months. 3. Documentation of substitutions made to the menu for the previous 6 months was not maintained. On at 12:10 PM, the dietary manager stated she printed out daily sheets of paper with the day's meal on it and included any changes she made to the draft menu she was given to use. After the day is over, she throws the paper away. She stated she was not informed of the requirement to maintain substitution for 6 months. The menu for lunch on week 3 of the draft the manager was using for Monday, , read citrus glazed salmon, roasted cauliflower, sautéed kale, assorted breads, key lime pie. The daily menu the manager had prepared for was observed at 9:47 AM and read baked salmon, yellow rice, peas, roll, pie. The dietary manager stated she did not have the citrus glaze ingredients, cauliflower or kale. She also did not have key lime pie. Prior to lunch, she changed the menu to read brown sugar teriyaki glazed salmon, sweet peas, yellow rice, ice cream social at 2 pm. The week 3 Monday lunch on the menu provided by the executive director at 2:30PM on read salmon, polenta triangle, grilled zucchini, assorted breads, assorted ice cream. On at 2:30 PM, the executive director stated she was unable to provide an original menu, signed and dated by a licensed dietician, or any dietician credentials. She stated the menu came from the corporate office. 4. Observations in the dining room prior to lunch found the tables set with some gold and some dark blue table linens and appropriate utensils	{A 093}		

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{A 093}	Continued From page 15 and glassware. The tablecloths were wrinkled and had white lint on them. Many were stained. One table in the corner had a large stain on the tablecloth. (photographic evidence obtained) 5. The facility had a census of 31 residents on . . . . , requiring a supply of 93 gallons of water (31 residents x 1 gallon per resident per day x 3 days) . Observation of the emergency food and water supply revealed there were ten 5-gallon collapsible containers filled with water. Nine were in a corner of the private dining room and one more was located in the kitchen. There was no information in the Comprehensive Emergency Management Plan (CEMP) that the facility was approved to use Collapsible containers for emergency water supply. Also, there was no mention of how they would provide water in an emergency in the CEMP On . . . . at 2:30 PM, the executive director state those were filled in , of Hurricane Dorian from the week of . . . . . She confirmed there was no other water available in the facility for use in the event of an emergency. Class III	{A 093}		
{A 152} SS=D	58A-5.023(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to Section 429.28(1)(a), F.S.;	{A 152}		

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{A 152}	Continued From page 16 2. Be maintained free of hazards; and 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to Section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable . . to ensure easy access by the resident; 2. A closet or wardrobe space for hanging clothes; 3. A dresser, or other furniture designed for storage of clothing or personal effects; 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . . . . . . This Statute or Rule is not met as evidenced by: DEFICIENCY REMAINED UNCORRECTED Based on observation and interview, the facility failed to maintain a clean and comfortable	{A 152}		

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{A 152}	Continued From page 17 environment for the residents and did not repair or replace carpets as needed. Findings: 1. Observations on at 10:30 AM, the facility found the carpeting in many locations throughout the facility to be stained or torn. 2. Observations on at 10:30 AM, In the dining room, where the carpet met the laminate flooring in the TV room, the carpet was torn. It was also torn on the opposite dining room entrance toward the private dining room. During the course of the survey stains were observed in hallways. (photographic evidence obtained) On at 12:30 PM, the executive director stated the carpets have been cleaned and she was aware of the ongoing issue. Class III	{A 152}		
{A 200} SS=G	58A-5.036 FAC Emergency Environmental Control (1) DETAILED EMERGENCY ENVIRONMENTAL CONTROL PLAN. Each assisted living facility shall prepare a detailed plan ("plan") to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency environmental control in the event of the loss of primary electrical power in that assisted living facility which includes the following information: (a) The acquisition of a sufficient alternate power source such as a generator(s), maintained at the	{A 200}		

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{A 200}	Continued From page 18	{A 200}		

assisted living facility, to ensure that current licensees of assisted living facilities will be equipped to ensure . . . . air temperatures will be maintained at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power.
1. The required temperature must be maintained in an area or areas, determined by the assisted living facility, of sufficient size to maintain residents safely at all times and that is appropriate for resident care needs and life safety requirements. For planning purposes, no less than twenty (20) net square . . . per resident must be provided. The assisted living facility may use eighty percent (80%) of its licensed bed capacity as the number of residents to be used in the . . . . . to determine the required square footage. This may include areas that are less than the entire assisted living facility if the assisted living facility's comprehensive emergency management plan includes allowing a resident to congregate when he or she desires in portions of the building where temperatures will be maintained and includes procedures for monitoring residents for signs of heat related injury as required by this rule. This rule does not prohibit a facility from acting as a receiving provider for evacuees when the conditions stated in Section 408.821, F.S., and subsection 58A-5.026(5), F.A.C., are met. The plan shall include information regarding the area(s) within the assisted living facility where the required temperature will be maintained.
2. The alternate power source and fuel supply shall be located in an area(s) in accordance with local zoning and the Florida Building Code.
3. Each assisted living facility is unique in size; the types of care provided; the physical and mental capabilities and needs of residents; the

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{A 200}	Continued From page 19 type, frequency, and amount of services and care offered; and staffing characteristics. Accordingly, this rule does not limit the types of systems or equipment that may be used to achieve temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. The plan shall include information regarding the systems and equipment that will be used by the assisted living facility and the fuel required to operate the systems and equipment. a. An assisted living facility in an evacuation zone pursuant to Chapter 252, F.S., must maintain an alternative power source and fuel as required by this subsection at all times when the assisted living facility is occupied but is permitted to utilize a mobile generator(s) to enable portability if evacuation is necessary. b. Assisted living facilities located on a single campus with other facilities under common ownership, may share fuel, alternative power resources, and resident space available on the campus if such resources are sufficient to support the requirements of each facility's residents, as specified in this rule. Details regarding how resources will be shared and any necessary movement of residents must be clearly described in the emergency power plan. c. A multistory facility, whose comprehensive emergency management plan is to move residents to a higher floor during a flood or surge event, must place its alternative power source and all necessary additional equipment so it can safely operate in a location protected from flooding or storm surge damage. (b) The acquisition of sufficient fuel, and safe maintenance of that fuel at the facility, to ensure that in the event of the loss of primary electrical power there is sufficient fuel available for the	{A 200}		

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{A 200}	Continued From page 20 alternate power source to maintain temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours after the loss of primary electrical power during a declared state of emergency. The plan must include information regarding fuel source and fuel storage. 1. Facilities must store minimum amounts of fuel onsite as follows: a. A facility with a licensed capacity of 16 beds or less must store 48 hours of fuel onsite. b. A facility with a licensed capacity of 17 or more beds must store 72 hours of fuel onsite. 2. An assisted living facility located in an area in a declared state of emergency area pursuant to Section 252.36, F.S., that may impact primary power delivery must secure ninety-six (96) hours of fuel. The assisted living facility may utilize portable fuel storage containers for the remaining fuel necessary for ninety-six (96) hours during the period of a declared state of emergency. 3. Piped natural gas is an allowable fuel source and meets the onsite fuel supply requirements under this rule. 4. If local ordinances or other regulations limit the amount of onsite fuel storage for the assisted living facility's location, then the assisted living facility must develop a plan that includes maximum onsite fuel storage allowable by the ordinance or regulation and a reliable method to obtain the maximum additional fuel at least 24 hours prior to depletion of onsite fuel. (c) The acquisition of services necessary to maintain, and test the equipment and its functions to ensure the safe and sufficient operation of the alternate power source maintained at the assisted living facility. (d) The acquisition and maintenance of a monoxide alarm.	{A 200}		

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{A 200}	Continued From page 21 (2) SUBMISSION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall submit its plan to the local emergency management agency for review within 30 days of the effective date of this rule. Assisted living facility plans previously submitted and approved pursuant to Emergency Rule 58AER17-1, F.A.C., will require resubmission only if changes are made to the plan. (b) Each new assisted living facility shall submit the plan required under this rule prior to obtaining a license. (c) Each existing assisted living facility that undergoes any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of its systems or equipment affecting the facility's compliance with this rule shall amend its plan and submit it to the local emergency management agency for review and approval. (3) APPROVED PLANS. (a) Each assisted living facility must maintain a copy of its approved plan in a manner that makes the plan readily available at the licensee's physical address for review by a legally authorized entity. If the plan is maintained in an electronic format, assisted living facility staff must be readily available to access and produce the plan. For purposes of this section, "readily available" means the ability to immediately produce the plan, either in electronic or paper format, upon request. (b) Within two (2) business days of the approval of the plan from the local emergency management agency, the assisted living facility shall submit in writing proof of the approval to the Agency for Health Care Administration. (c) The assisted living facility shall submit a	{A 200}		

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consumer-friendly summary of the emergency power plan to the Agency. The Agency shall post the summary and notice of the approval and implementation of the assisted living facility emergency power plans on its website within ten (10) business days of the plan's approval by the local emergency management agency and update within ten (10) business days of implementation.
(4) IMPLEMENTATION OF THE PLAN.
(a) Each assisted living facility licensed prior to the effective date of this rule shall, no later than . . . , . . . , have implemented the plan required under this rule.
(b) The Agency shall allow an extension up to . . . , . . . to providers in compliance with subsection (c), below, and who can show delays caused by necessary construction, delivery of ordered equipment, zoning or other regulatory approval processes. Assisted living facilities shall notify the Agency that they will utilize the extension and keep the Agency apprised of progress on a quarterly basis to ensure there are no unnecessary delays. If an assisted living facility can show in its quarterly progress reports that unavoidable delays caused by necessary construction, delivery of ordered equipment, zoning or other regulatory approval processes will occur beyond the initial extension date, the assisted living facility may request a waiver pursuant to Section 120.542, F.S.
(c) During the extension period, an assisted living facility must make arrangements pending full implementation of its plan that provides the residents with an area or areas to congregate that meets the safe indoor air temperature requirements of paragraph (1)(a), for a minimum of ninety-six (96) hours.
1. An assisted living facility not located in an

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evacuation zone must either have an alternative power source onsite or have a contract in place for delivery of an alternative power source and fuel when requested. Within twenty-four (24) hours of the issuance of a state of emergency for an event that may impact primary power delivery for the area of the assisted living facility, it must have the alternative power source and no less than ninety-six (96) hours of fuel stored onsite.
2. An assisted living facility located in an evacuation zone pursuant to Chapter 252, F.S., must either:
a. Fully and safely evacuate its residents prior to the arrival of the event, or
b. Have an alternative power source and no less than ninety-six (96) hours of fuel stored onsite, within twenty-four (24) hours of the issuance of a state of emergency for the area of the assisted living facility.
(d) Each new assisted living facility shall implement the plan required under this rule prior to obtaining a license.
(e) Existing assisted living facilities that undergo any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of the systems or equipment affecting the assisted living facility's compliance with this rule shall implement its amended plan concurrent with any such additions, modifications, alterations, refurbishment, renovations or reconstruction.
(f) The Agency for Health Care Administration may request cooperation from the State Fire Marshal to conduct inspections to ensure implementation of the plan in compliance with this rule.
(5) POLICIES AND PROCEDURES.
(a) Each assisted living facility shall develop and implement written policies and procedures to

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{A 200}	Continued From page 24 ensure that the assisted living facility can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. The procedures shall ensure that residents do not experience complications from fluctuations in air temperatures inside the facility. Procedures must address the care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury including: 1. The use of cooling devices and equipment; 2. The use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration; 3. Wellness checks by assisted living facility staff to monitor for signs of , and heat injury; and, 4. A provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy. (b) Each assisted living facility shall maintain the written policies and procedures in a manner that makes them readily available at the licensee's physical address for review by a legally authorized entity. If the policies and procedures are maintained in an electronic format, assisted living facility staff must be readily available to access the policies and procedures and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce the policies and procedures, either in electronic or paper format, upon request. (c) The written policies and procedures must be readily available for inspection by each resident; each resident's legal representative, designee, surrogate, guardian, attorney in fact, or case manager; each resident's estate; and such	{A 200}		

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additional parties as authorized in writing or by law.
(6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this rule, the Agency for Health Care Administration may seek any remedy authorized by Chapter 429, Part I, F.S., or Chapter 408, Part II, F.S., including, but not limited to, license revocation, license suspension, and the imposition of administrative fines.
(7) COMPREHENSIVE EMERGENCY MANAGEMENT PLAN.
(a) Assisted living facilities whose comprehensive emergency management plan is to evacuate must comply with this rule.
(b) Each facility whose plan has been approved shall submit the plan as an addendum with any future submissions for approval of its comprehensive emergency management plan.
(8) NOTIFICATION.
(a) Within five (5) business days, each assisted living facility must notify in writing, unless permission for electronic communication has been granted, each resident and the resident's legal representative:
1. Upon submission of the plan to the local emergency management agency that the plan has been submitted for review and approval;
2. Upon final implementation of the plan by the assisted living facility.
(b) Each assisted living facility must maintain a copy of each notification set forth in paragraph (a), above, in a manner that makes each notification readily available at the licensee's physical address for review by a legally authorized entity. If the notifications are maintained in an electronic format, facility staff must be readily available to access and produce the notifications. For purposes of this section,

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{A 200}	Continued From page 26 "readily available" means the ability to immediately produce the notifications, either in electronic or paper format, upon request. This Statute or Rule is not met as evidenced by: DEFICEINCY REMAINED UNCORRECTED Based on observation, policy review and interview the facility failed to maintain a copy of the facility's current Emergency Power Plan (EPP) and the approval letter from the county Office of Emergency Management (OEM), failed to develop and implement policies and procedures to ensure the assisted living facility can effectively and immediately activate, operate and maintain the alternate power source, failed to develop and implement policies and procedures outlining the use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration, and failed to train all staff upon hire in the operation of the alternate power source and procedures to ensure resident safety, as required in 58A- 5.036 FAC. Findings: 1. Request to review of the facility EPP approval letter from the county OEM revealed the executive director had not received the county approval letter. Review of the facility emergency power plan revealed it was the same version of the plan reviewed on . . . . . and was entitled Emergency Environmental Control Plan and dated . . . . . There were 6 brief sections indicating they had 3 generators and, including Section V (Fuel Storage- TBD) (to be determined) which detailed 2 options for storing gasoline in "round or square" tanks and the name of a fuel vendor. Section VI (Maintenance & Testing)	{A 200}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965589	A. BUILDING: _____ B. WING _____	R 09/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A 200}	Continued From page 27 outlined their planned timeline for testing by "competent personnel" but did not indicate who would do the testing. The section noted written records would be maintained. The next page noted all of the above information again. There was a facility floor plan. The final page was entitled "Clinical Protections in Power Emergency" and included 10 brief steps. Review of the plan revealed it did not indicate how temperature would be monitored or how and when wellness checks would be conducted to monitor for signs of heat related injury. Observations during a tour of the facility found there were 2 portable generators present, not 3. They were located in the maintenance room accessed from the outside of the facility. There were two 74 gallon containers of gasoline present and located outside the facility in a vinyl tent/dining canopy. The executive director stated they were full. She stated there were an additional 4 each of 5 gallon containers, also full with gasoline. She was unable to state how many hours of power that would supply to the facility. No written records regarding testing or maintenance were available for review. (photographic evidence obtained) 2. On at 11:10 AM, the executive director stated no policies and procedures for effectively and immediately activating, operating and maintaining the alternate power source were available for review . She stated it was the maintenance director's job to do the weekly testing, but confirmed she did not have any records of the testing. It was later revealed the	{A 200}		

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{A 200}	Continued From page 28 maintenance director was no longer employed at the facility as of and that position remained open on . . . . . 3. Review of the facility plan did not find any language which addressed the use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration. On . . . . at 11:20 AM, the executive director confirmed there were no policies for review. 4. There was no documentation indicating training of staff on the procedures that are to be followed in a power outage. On at 11:20 AM, the executive director confirmed there were no policies for review. On . . . . at 2:30 PM, the executive director confirmed she was unable to provide the county approval letter and their actual plan. She confirmed she did not have policies and procedures for monitoring residents and maintaining medications requiring refrigeration, testing and maintaining the generators or for training staff members on what to do in a power outage. Class II	{A 200}		