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
	AL11965645	A. BUILDING: _____ B. WING _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GULF BREEZE COURTYARD	3428 GULF BREEZE PARKWAY GULF BREEZE, FL 32561

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A 000	Initial Comments An unannounced biennial survey with specialty license limited mental health (LMH) and limited nursing services (LNS) in conjunction with complaint investigations (2019018537, 2019018699, 2019020131 and 2020001453) was conducted at Gulf Breeze Courtyard Assisted Living Facility on thru . At the time of survey there were deficiencies identified.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of or , , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and	A 025		

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A 025	Continued From page 1 physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation and staff interview, the facility failed to provide personal supervision as appropriate for 3 of 16 residents reviewed (resident #9, #10 and #19). Night shift staff failed to get up or check for resident elopement when the main entrance door alarm sounded. Night shift staff were unsure of resident room locations, and unable to demonstrate room checks being performed (#9 & #10). The facility also failed to ensure staff were able to demonstrate competency in the implementation of the elopement response policies and procedures. This failure led to the facility staff being unaware of the elopement of Resident #19 in . . . . until reported by the store clerk and police. The findings include: Resident #9 and #10	A 025		

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A 025	Continued From page 2 During the night hours of at approximately 01:00 AM, two surveyors entered the facility. The alarm sounded. The main lobby was dark. No facility staff came to the door or lobby. No staff checked on the alarm or investigated why it was sounding. A television was playing in the small television/library room in between the dining room and the main lobby. Resident #9 was noted walking in the lobby near the fireplace. No staff were noted interacting with the resident. The surveyors called out, "Hello" loudly three times. One staff member peaked her around the corner of a chair in the television room without getting up. The surveyors entered the television room and observed 2 staff members (Staff G and H) sitting in chairs with blankets covering the employees from their necks to their . . . A current resident census was requested and provided by staff G and H. There were 16 residents listed on the census. Beginning about 1:30 AM on , a complete 100% observation of all current residents was conducted with staff G and H to ensure all residents were in the building. Resident #10 could not initially be located. Resident #10 was list as residing in . . . . . , but that room was unoccupied. An interview was conducted with Staffs G and H who were unsure of what resident #10 looked like or the room location for resident #10. The staff asked the surveyors, if the surveyors were sure that resident #10 was actually in the facility. Neither staff had an updated resident room list. Resident #10 was eventually located in another room. Staff members G and H stated that there is "supposed to be a book" to log the 2 hour resident checks. Neither staff were able to provide the log book.	A 025		

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A 025	Continued From page 3 Both staff stated they were not trained in the required logbook documentation. Resident #19 On [redacted] at approximately 9:09 AM, an interview was conducted with Employee C. Employee C reported that the facility had not conducted elopement drills. Employee C related an incident in [redacted] where resident #19 eloped next door to a convenient store and threatened the store clerk to rob the store for cigarettes. The store clerk called law enforcement and the facility, and the resident was taken to the behavioral center for assessment. On [redacted] at approximately 9:56, an interview was conducted with Employee D. Employee D confirmed the elopement in [redacted] where a resident eloped from the facility to convenient store next door and tried to rob the store. On [redacted] at approximately 8:15 AM, a follow-up interview was conducted with employee D to receive full capture of the elopement for resident #19. Employee D reported that the day resident #19 eloped he was on duty. Employee D verified that none of the residents at the facility were to leave the premises unless accompanied by staff or family members. Employee D reported that the incident occurred either [redacted] or [redacted]. On that day resident #19 wanted to go get cigarettes. Employee D stated that he explained to resident #19 that the facility had cigarettes and tried to give the resident a pack of cigarettes, but the resident refused. Employee D reported that he did not know where other staff and the Executive Director was located in building and staff was not aware that resident #19 had kicked [redacted] boards from the gate and left the premises going over to	A 025		

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A 025	Continued From page 4 the convenience store next door. Employee D reported that after the resident refused cigarettes, the resident stated that he was going outside to get some air. Employee D reported about fifteen minutes later, the store clerk came over to facility and informed the Executive Director that resident #19 had been over to the store and threatened to rob the store for cigarettes and cigarette lighters. Employee D reported that the store clerk informed the Executive Director that the store had called law enforcement to come investigate. Employee D reported that law enforcement arrived at the facility and found the cigarettes and lighter on resident's possession. The cigarettes and lighter were returned to store clerk who did not press charges since items were returned. Resident was taken to behavioral center to receive mental evaluation. Employee D reported that the Executive Director reported the elopement to the Director of Clinical Operations who wanted to complete the adverse incident report. On at approximately 1:00 PM, a telephone interview was conducted with Employee E. Employee E reported no staff observed resident #19 leaving the facility and did not know resident had left the facility until the store clerk came over to facility and informed the Executive Director that resident had robbed the store taking cigarette and lighter. Employee E reported that resident #19 was taken to behavioral center via ambulance. Class II	A 025		
A 026 SS=D	59A-36.007(2) FAC Resident Care - Social & Leisure Activities	A 026		

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A 026	Continued From page 5 (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 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, resident interview, staff interview and hospice staff interview, the facility	A 026		

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A 026	Continued From page 6 failed to provide diversified individual and group activities and failed to demonstrate residents' participation in activities or activities planning. No activities were observed during the 4 days of the survey from [redacted] through [redacted]. Residents were observed unengaged, sitting with nothing to do and [redacted] aimlessly. An activities calendar was posted, but was not followed. This failure affected all 16 current residents including resident #5. The findings include: The posted activity calendar in the main lobby for [redacted], 29 and 30 listed the following activities: [redacted]: 0900 AM Courtyard Walk, 10:00 AM Snack, 11:30 AM Bingo, 1:30 PM Crafts, 3:00 PM Snack, 4:00 PM Movie [redacted]: 0900 AM Courtyard Walk, 10:00 AM Snack, 11:30 AM Bingo, 2:30 PM Hydration Station, 3:00 PM Snack, 4:00 PM Movie [redacted]: 0900 AM Courtyard Walk, 10:00 AM Snack, 11:30 AM Bingo, 1:30 PM Crosswords, 3:00 PM Snack, 4:00 PM Movie [redacted]: 0900 AM Courtyard Walk, 10:00 AM Snack, 11:30 AM Bingo, 1:30 PM Bowling, 3:00 PM Snack, 4:00 PM Movie Observation of the great room where activities should be conducted on [redacted] at approximately 1:30 PM revealed that the posted 1:30 PM Crafts activity was not announced nor was it conducted. There were approximately residents in the room. They were observed to be lying on furniture, sitting on furniture and aimless [redacted] around. They were not observed to be engaged by staff in any manner.	A 026		

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A 026	Continued From page 7 Observation on at approximately 09:00 AM revealed that the posted 09:00 AM Courtyard Walk activity was not announced nor was it conducted. Observation of the great room on at approximately 11:45 AM revealed that the posted 11:30 AM Bingo activity was not announced nor was it conducted. Residents were again observed around the room or lying on furniture unengaged. Interview with the hospice Registered Nurse K (RN K) on at approximately 1:00 PM revealed concerns regarding lack of facility staff engagement with hospice residents to participate in social, recreational, educational and other activities. RN K stated, "The staff don't do much at all here. It has changed significantly since , downhill." Staff K indicated that the hospice leadership had forwarded concerns to a state agency. Interview with resident #5 on at approximately 1:30 PM indicated that the resident did not participate in facility activities. Resident #5 stated, "No!" emphatically and loudly with direct contact when asked if he participated in activities and if staff came into his room to encourage participation in activities, games or other events. Observation on at approximately 11:45 AM revealed that the posted 11:30 AM Bingo activity was not announced nor was it conducted. There were approximately 5 residents in the room. They were observed to be lying on furniture, sitting on furniture and aimlessly around. They were not observed to be	A 026		

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A 026	Continued From page 8 engaged by staff in any manner. Observation on [redacted] at approximately 1:45 PM revealed that the posted 1:30 PM Crosswords activity was not announced nor was it conducted. There were approximately 6 residents in the room. They were observed to be sitting on furniture and aimlessly [redacted] around. They were not observed to be engaged by staff in any manner. Observation on [redacted] at approximately 09:35 AM revealed 4 residents observed walking around aimlessly in the main lobby. There were 3 residents noted seated in the library/TV room and 1 resident noted seated in dining room. There were no staff present in the dining room, lobby or TV/library room. There were no activities occurring. Observation on [redacted] at approximately 11:30 AM revealed that the posted 11:30 AM Bingo activity was not announced nor was it conducted. Two residents were observed shuffling in main lobby-heads down, one resident was sitting unengaged in the dining room and one resident was observed standing-up but bending over at the waist plucking at the rug in the main lobby. There were no activities occurring, no staff present, and no interaction with residents observed. Interview with the Activities Director (AD), on [redacted] at approximately 2:15 PM in [redacted], revealed that the AD was recently "promoted" to the activities director position. The AD stated that he did not receive activity director specific training and was told that the position, "...was common sense." The AD stated that he developed the [redacted] activities calendar	A 026		

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A 026	Continued From page 9 based on review of past activities calendars. The AD confirmed that he did not maintain minutes for resident council meetings, that he did not perform individual activity assessments with the residents and that the bingo, movie, crossword and walk activities posted on the activities calendar were not conducted on . . . . . and . . . . . . The AD stated that on , the activity schedule was amended to include bowling. The AD stated that he was assigned to work as a Resident Assistant ( ) on . . . . . and on . . . . . and that he tries to perform the AD duties but that it is"...hard to multitask," when he is scheduled as an . The AD confirmed that no individual resident specific activities were conducted with resident #5. An interview was conducted with the Operations Director, staff J on . . . . . at approximately 3:00 PM in . Staff J confirmed that the activities director had not received position specific training. Staff J stated that the "...activity schedule was not up to par." Observation on . . . . . at approximately 4:00 PM revealed that the posted 4:00 PM Movie activity was not announced nor was it conducted. Class III	A 026		
A 028 SS=D	59A-36.007(4) FAC Resident Care - Activities of Daily Living (4) ACTIVITIES OF DAILY LIVING. Facilities must offer supervision of or assistance with activities of daily living as needed by each resident. Residents should be encouraged to be as independent as possible in performing activities of daily living.	A 028		

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A 028	Continued From page 10 This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide supervision of or assistance with activities of daily living for 1 of 16 residents observed, (resident #2). The findings include: Resident #2 was observed sitting in a wheelchair in the main lobby on Tuesday morning, [redacted] at approximately 11:45 AM. Large amount of white flakes were noted along the front and [redacted] of the and collar line of the resident's shirt. An interview was conducted during the observation with Resident #2 who stated that she shampoo's her hair about every 2 weeks. Resident #2 stated that she had not had a shampoo for at least 2 weeks and that she wanted assistance with hair shampoo. Class III	A 028		
A 032 SS=G	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 032		

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A 032	Continued From page 11 (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 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,	A 032		

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A 032	Continued From page 12 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)(l), F.S. This Statute or Rule is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure staff received training on the facility's resident elopement response policies and procedures. The facility failed to ensure staff were able to demonstrate competency in the implementation of the elopement response policies and procedures. This failure led to the facility staff being unaware of the elopement of Resident #19 in . . . . . until reported by the store clerk and police. The findings included: On at approximately 9:09 AM, an interview was conducted with Employee C. Employee C was asked if the facility conducted elopement drills and how many had he participated in? Employee C reported that the facility had not conducted elopement drills. Employee C related an incident in . . where resident #19 eloped next door to a convenient store and threatened the store clerk to rob the store for cigarettes. The store clerk called law enforcement and the facility and the resident was taken to the behavioral center for assessment. Employee C reported that staff did not receive elopement training after this elopement.	A 032		

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A 032	Continued From page 13 On at approximately 9:56, an interview was conducted with Employee D. Employee D confirmed the elopement in , where a resident eloped from the facility to convenient store next door and tried to rob the store. Employee D stated he has not participated in any elopement drills, nor has he received any elopement training to date. On at approximately 2:46 PM, an interview was conducted with Employee F. Employee F was asked if the facility conducted elopement drills and how many had she participated in? Employee F reported that she had not participated in any elopement drills since she been working at the facility. On at approximately 8:15 AM,a follow-up interview was conducted with employee D to receive full capture of the elopement for resident #19. Employee D reported that the day resident #19 eloped he was on duty. Employee D verified that none of the residents at the facility were to leave the premises unless accompanied by staff or family members. Employee D reported that the incident occurred either or . On that day resident #19 wanted to go get cigarettes. Employee D stated that he explained to resident #19 that the facility had cigarettes and tried to give the resident a pack of cigarettes, but the resident refused. Employee D reported that he did not know where other staff and the Executive Director was located in building and staff was not aware that resident #19 had kicked boards from the gate and left the premises going over to the convenience store next door. Employee D reported that after the resident refused cigarettes, the resident stated that he was going outside to get some air. Employee D reported about fifteen	A 032		

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A 032	Continued From page 14 minutes later, the store clerk came over to facility and informed the Executive Director that resident #19 had been over to the store and threatened to rob the store for cigarettes and cigarette lighters. Employee D reported that the store clerk informed the Executive Director that the store had called law enforcement to come investigate. Employee D reported that law enforcement arrived at the facility and found the cigarettes and lighter on resident's possession. The cigarettes and lighter were returned to store clerk who did not press charges since items were returned. Resident was taken to behavioral center to receive mental evaluation. Employee D reported that the Executive Director reported the elopement to the Director of Clinical Operations who wanted to complete the adverse incident report. On at approximately 11:00 AM, interview conducted with Director of Clinical Operations to request documentation for elopement drills conducted by the facility. Director of Clinical Operations provided three elopement drills dated (. . . . . _, ... and . . . .). The elopement drills did not include any employee's names who had participated in the elopement drill. When asked Director of Clinical Operations to produced names of staff who had participated in elopement drills she reported that she could not produce the documentation because the previous executive director was not good record keeper. The facility had no in-service training for elopements after the elopement of Resident #19 in . On at approximately 1:00 PM, a telephone interview was conducted with Employee E. Employee E was asked if the facility conducted elopement drills and how many had she participated in? Employee E reported she	A 032		

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A 032	Continued From page 15 had not received elopement training and the facility still had not provided elopement training even after a resident eloped from the facility. Employee E reported no staff observed resident #19 leaving the facility and did not know resident had left the facility until the store clerk came over to facility and informed the Executive Director that resident had robbed the store taking cigarette and lighter. Employee E reported that resident #19 was taken to behavioral center via ambulance. A record review was conducted of employees C, D, E and F personnel files to find incomplete in-service training regarding the facility's resident elopement response policies and procedures. The elopement form did not identify names of staff receiving training. There was no evidence that the facility evaluated the employees competence in implementing elopement policies. Employee C, a resident assistant, was hired . Employee C was promoted to Activity Director on . Employee D, a resident assistant, was hired on . Employee E, a resident assistant, was hired on . Employee F, a resident assistant, was hired . Class II	A 032		
A 075 SS=D	429.255( ) FS Use of Personnel; Emergency Care ( ) (3)(a) An assisted living facility licensed under this part with 17 or more beds shall have on the premises at all times a functioning automated external defibrillator as defined in s. 768.1325(2)	A 075		

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A 075	Continued From page 16 (b). (b) The facility is encouraged to register the location of each automated external defibrillator with a local emergency medical services medical director. (c) The provisions of ss. 768.13 and 768.1325 apply to automated external defibrillators within the facility. (4) Facility staff may withhold or withdraw , , or the use of an automated external defibrillator if presented with an order not to executed pursuant to s. 401.45. The agency shall adopt rules providing for the implementation of such orders. Facility staff and facilities may not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing , , , or use of an automated external defibrillator pursuant to such an order and rules adopted by the agency. The absence of an order to executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing , , , or use of an automated external defibrillator as otherwise permitted by law. (5) The agency may adopt rules to implement the provisions of this section relating to use of an automated external defibrillator. This Statute or Rule is not met as evidenced by: Based on observation of the facility's Automated External Defibrillator ( ) and interview with the facility's nursing staff, the facility failed to have an operational on premise for 1 of 1 's reviewed. The findings include:	A 075		

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A 075	Continued From page 17 On [redacted], at approximately 12:30 PM, observation of the facility's [redacted] in the nurses station with nursing staff B revealed that the defibrillator pads had an expiration date of [redacted]. No other [redacted] pads found in kit. Staff B acknowledged the expired [redacted] pads, stating that the interim facility Director of Clinical Operations, staff J was notified. Photographic evidence was obtained. Class III	A 075		
A 152 SS=D	59A-36.014(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.; 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 [redacted] to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, [redacted] or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor	A 152		

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A 152	Continued From page 18 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: Based on observation and staff interview, the facility failed to provide a safe living environment, free of hazards, and ensuring that all structural systems are in good working order, including resident's bathrooms. This effected the lobby area, the . . . hallway 1600, resident #2's heating unit, resident #13's bathroom sink and shower and resident #15's shower for hot water. The Findings included: On at approximately 11:00 AM, upon entrance into the facility, a meeting was held with the Executive Director (ED) and immediately afterward a tour was conducted of the facility. The Executive Director reported no maintenance staff since , but has been using maintenance staff from another facility. The ED stated the maintenance staff has not been at the facility in about two weeks. Record review of employee roster indicated maintenance staff last day in position was . . . . On during the tour, an observation was made of the lobby area. Near the side exit door	A 152		

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A 152	Continued From page 19 which exited out into the courtyard, there was floor to ceiling exposed drywall as well a hole in the ceiling causing a draft through the lobby. Interview with Executive Director who reported that termites had caused the problem. She stated that there were a dispute between the corporate office and the pest control company of who would repair the damage. Residents #1, #6, #10 and #12 were sitting in the lobby area and reported that it was sitting in the common area/lobby due to the draft from the hole. (photographic evidence obtained) The 1600 hallway was observed to find flooring partially ripped up (tripping hazard). Observation revealed no warning signs, nor was the area closed off to prevent any residents from walking through the area. Executive Director reported that the previous maintenance had started the project before resigning (over 4 months ago) and the project had not been completed. Record review indicated that maintenance resigned on . . . . . The Director of Clinical Operations reported that she had documentation that the facility had a plan in place to complete the repairs with the hole in the lobby and repairs for hallway 1600. (photographic evidence obtained) On at approximately 11:58 AM, during continued tour, an observation of resident #2 in her room with family. Resident #2's son and daughter-in-law reported that the heater was not working in the room and had not been working since these last snaps. Resident's son reported that he was very upset that his mother's heater was not working. Resident #2 reported that she would stay out of the room all day and around 7:00pm she would return to her room, go to bed and get under the covers to go to sleep.	A 152		

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A 152	Continued From page 20 Resident's son reported that he had informed the Executive Director and she had not done anything about it. Resident #2 reported she had been living in the facility about two months and confirmed that she had no heat in the room during these last spells. Resident reported that she had informed the Executive Director about five days ago. Resident reported that on one occasion the dietary manager came in and looked at heater unit and found it not to be working, and the room was , then the dietary manager informed the Executive Director. Resident reported that the Executive Director came to her room and stated it was in the room and left and the Executive Director had not returned. Resident #2 reported no repairmen had come to examine the heating unit. On at approximately 12:00pm, during lunch observation, Resident #1 stated that she was in the dining room. Observations were made of several other residents in the dining room area pulling and wrapping sweaters around their bodies, saying it was in here. Resident #1 also reported that she was in lobby area from the draft through the hole in the ceiling. On at 10:40 AM, an observation and interview were conducted of resident #15's room. Observation of resident's room revealed no hot water in the shower. Resident #15 reported that she has not had hot water in her shower for over a month. She stated that she has told everyone who would listen and no one has done anything about it. Resident #15 reported that the hot water runs in the sink, and hospice staff had been giving her sponge baths, but she was tired and aggravated with not having hot water and not being able to shower. She stated that she either wanted the facility to fix her shower to receive hot	A 152		

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A 152	Continued From page 21 water or move her in another room until the shower was fixed. Resident #15 reported no staff had offered to move her to another room. Observation of the license for Gulf Breeze Courtyard reveal the facility is licensed for 80 residents, and the current census was only 16. Multiple resident rooms were observed unoccupied. On at approximately 1:53 PM, interview with resident #15's son reported that he received a telephone call from the Hospice nurse that his resident #15 was being moved to another room. He stated that he came to ensure that all her belongings were properly moved. Resident #15's son reported during this interview that he had complained about the lack of hot water for about 3 months. He stated that he had personally informed the Executive Director, and nothing had gotten done. He further stated that the light in her closet was out for a while, he complained about that to staff and Executive Director until he got tired, then went and purchased the light bulb himself and installed it in the closet so that resident #15 could have light when entering the closet. On at approximately 10:55 AM, an observation of resident #13's room was conducted. Resident #13 was not in the room, and observed laying on a sofa in the common area. Observation of resident #13's bathroom with the licensed practical nurse (LPN) found the sink clogged and standing water present in the sink. The LPN turned the shower on, and no water flowed from the shower . The Director of Clinical Operations also observed and confirmed the clogged sink with standing water and shower not working.	A 152		

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A 152	Continued From page 22 On . . . . . during observation of the facility on night shift at about 2:00 AM, a very strong odor was noted in the 1600 hallway. The . . . . odor became noxious upon entering the resident #1's room. Observation of resident #1's room revealed resident #1 curled up in her recliner asleep. Employee G and H reported that they did know where the strong odor was coming from inside the resident's room, but thought it might be coming from the recliner where the resident was sleeping. Interview with staffs G and H on . . . . . at approximately 2:45 AM revealed that numerous efforts to clean and deodorize resident #1's room were performed without elimination of the noxious odor. Class III	A 152		
A 161 SS=D	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the	A 161		

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A 161	Continued From page 23 employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in section 429.174, F.S., and rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity , to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on staff interview and personnel record review, the facility failed to ensure that 1 of 6	A 161		

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A 161	Continued From page 24 sampled employee's (employee E) personnel file contained a copy of the employment application with references. The facility also failed to ensure that 3 of 6 employee's personnel files (D, E and F) contained documentation verifying freedom from signs of symptoms of communicable . . . . . and evidence of negative . . . . . . The facility also failed to ensure that 6 of 6 personnel files (A, B, C, D, E and F) contained documentation verifying participation in resident's elopement drills. The Findings included: A record review was conducted of employee E's personnel file to find no documentation for an employment application with references. A record review was conducted of employees D, E and F personnel files to find no documentation verifying freedom from signs of symptoms of communicable and no evidence of negative . . . . . . A record review was conducted of employees A, B, C, D, E and F personnel files to find incomplete documentation of elopement drills. The documentation failed to identify the staff who had participated in the elopement drills. The facility had a resident to elope in . The resident eloped from the facility to a convenient store next door and tried to rob the store. The resident left the facility without staff knowledge, and post event, there was no documentation that employees had participated in elopement drills. Employee A, Executive Director, was hired . . Employee B, Licensed Practical Nurse (LPN).	A 161		

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A 161	Continued From page 25 Employee was hired on . Employee C, a resident assistant, was hired . . . . . Employee C was promoted to Activity Director on . Employee D, a resident assistant, was hired on . Employee E, a resident assistant, was hired on . Employee F, a resident assistant, was hired . On at approximately 11:00 AM, an interview was conducted with the Director of Clinical Operations who reviewed the files and found none of the above documentation. The Director of Clinical Operations stated that she could not produce the documentation. Class III	A 161		
A 165 SS=D	429.23(&) FS; 59A-36.016 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means:	A 165		

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A 165	Continued From page 26 (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency	A 165		

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A 165	Continued From page 27 pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. 59A-36.016 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to rule 59A-35.110, F.A.C., which requires online	A 165		

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A 165	Continued From page 28 reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1), above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on staff interview and record review, the facility failed to file an initial adverse incident report within 1 business day after an elopement for resident #19 and the facility also failed to submit a full adverse incident report within 15 days after the elopement for resident #19. The findings included: On at approximately 9:09 AM, an interview was conducted with Employee C. Employee C was asked if the facility conducted elopement drills and how many had he participated in? Employee C reported that the facility had not conducted elopement drills. Employee C related an incident in where resident #19 eloped next door to a convenient store and threatened the store clerk to rob the store for cigarettes. The store clerk called law enforcement and the facility and the resident was taken to the behavioral center for assessment. Employee C reported that staff did not receive elopement training after this elopement. On at approximately 9:56, an interview was conducted with Employee D. Employee D confirmed the elopement in where a resident eloped from the facility to convenient store next door and tried to rob the	A 165		

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A 165	Continued From page 29 store. Employee D stated he has not participated in any elopement drills, nor has he recieved any elopement training to date. On [redacted] at approximately 11:20 AM, an interview was conducted with the Director of Clinical Operations concerning the elopement or resident #19 and requesting the adverse incident report. The Director of Clinical Operations reported that the facility did not have a hard copy of the adverse incident due to not being not able to print from her computer since she did not have the adverse incident report number. The Director of Clinical Operations was unable to show that an adverse incident report had been submitted. On [redacted] at approximately 1:49 PM, contact was made with the area office Field Office Manager at the Agency for Health Care Administration. The Field Office Manager searched the for facility submitted adverse incident reports. No adverse incident report had been filed for resident #19's elopement. On [redacted] at approximately 1:50 PM, a second interview with the Director of Clinical Operations who was informed that no adverse incident report had been submitted for resident #19 elopement. The Director of Clinical Operations reported at this time that the Executive Director had called her via telephone to discuss the elopement, but she never saw the report and the Executive Director lead her to believe she had filed the adverse incident report. On [redacted] at approximately 8:15 AM, interview was conducted with employee D to receive full capture of the elopement for resident #19. Employee D reported that the day resident #19 eloped he was on duty. Employee D verified that	A 165		

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A 165	Continued From page 30 none of the residents at the facility were to leave the premises unless accompanied by staff or family members. Employee D reported that the incident occurred either or . On that day resident #19 wanted to go get cigarettes. Employee D stated that he explained to resident #19 that the facility had cigarettes and tried to give the resident a pack of cigarettes, but the resident refused. Employee D reported that he did not know where other staff and the Executive Director was located in building and staff was not aware that resident #19 had kicked boards from the gate and left the premises going over to the convenience store next door. Employee D reported that after the resident refused cigarettes, the resident stated that he was going outside to get some air. Employee D reported about fifteen minutes later, the store clerk came over to facility and informed the Executive Director that resident #19 had been over to the store and threatened to rob the store for cigarettes and cigarette lighters. Employee D reported that the store clerk informed the Executive Director that the store had called law enforcement to come investigate. Employee D reported that law enforcement arrived at the facility and found the cigarettes and lighter on resident's possession. The cigarettes and lighter were returned to store clerk who did not press charges since items were returned. Resident was taken to behavioral center to receive mental evaluation. Employee D reported that the Executive Director reported the elopement to the Director of Clinical Operations who wanted to complete the adverse incident report. Class III	A 165		

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A 200	Continued From page 31	A 200		
A 200 SS=D	59A-36.025 FAC Emergency Environmental Control 59A-36.025 Emergency Environmental Control for Assisted Living Facilities. (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 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	A 200		

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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 59A-36.019(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 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

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A 200	Continued From page 33 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 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.	A 200		

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A 200	Continued From page 34 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. (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 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	A 200		

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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 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 paragraph (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

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A 200	Continued From page 36 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 subsection (1) (a) for a minimum of ninety-six (96) hours. 1. An assisted living facility not located in an 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	A 200		

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A 200	Continued From page 37 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 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	A 200		

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A 200	Continued From page 38 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 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, 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:	A 200		

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A 200	Continued From page 39 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, "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: Based on observation, record review, and staff interview, the facility failed to maintain a copy of its approved Comprehensive Emergency Management Plan (CEMP), failed to immediately produce the plan, either in electronic or paper format, upon request, and failed to immediately produce the CEMP notifications provided to each resident and the resident's legal representative, either in electronic or paper format for 2 of 2 resident records reviewed, (residents # 2, #5). The findings include: The Comprehensive Emergency Management Plan (CEMP), Emergency Power Plan (EPP) and fire inspection documentation was requested on at approximately 11:30 AM. On at approximately 12:15 PM the Director of Clinical Operations, staff, J provided a copy of the Sprinkler inspection dated ;	A 200		

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A 200	Continued From page 40 the Gas generator meter connection receipt dated , and the City of Gulf Breeze Public Services Coordinator letter dated , . Staff J was unable to locate the current CEMP or EPP. A CEMP dated 2010, 9 years ago, was located in the records office inside the nurses station. A record review was conducted on for resident #2. There was no notification to the resident or the resident's legal representative of the approved CEMP plan found. A record review was conducted on for resident #5. There was no notification to the resident or the resident's legal representative of the approved CEMP plan found. On at approximately 3:15 PM, during the generator assessment and interview with the Director of Clinical Operations, staff J, she confirmed that a CEMP and EPP was approved and implemented on and that there have been no changes to the plan other than a new interim ED effective . Staff J stated that a copy of the approved plan was requested from the Santa Rosa Emergency Management Services and should be available by Thursday for surveyor review. Staff J stated that the facility residents or their legal representative received notification of the submitted and approved CEMP and that she was in the process of accessing the electronic documentation of the resident CEMP notifications. As of , 3:30 PM, the facility was unable to produce the approved CEMP either in electronic or paper format. The facility was also unable to produce the CEMP notifications	A 200		

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A 200	Continued From page 41 provided to each resident and the resident's legal representative, either in electronic or paper format. Class III	A 200		
AL243 SS=D	429.075(1) FS; 59A-36.011(9) FAC LMH - Training 429.075 (1) To obtain a limited mental health license, a facility must hold a standard license as an assisted living facility, must not have any current uncorrected violations, and must ensure that, within 6 months after receiving a limited mental health license, the facility administrator and the staff of the facility who are in direct contact with mental health residents must complete training of no less than 6 hours related to their duties. This designation may be made at the time of initial licensure or relicensure or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with this part, part II of chapter 408, and applicable rules. This training must be provided by or approved by the Department of Children and Families. 59A-36.011 (9) LIMITED MENTAL HEALTH TRAINING. (a) Pursuant to section 429.075, F.S., the administrator, managers and staff, who have direct contact with mental health residents in a licensed limited mental health facility, must receive the following training: 1. A minimum of 6 hours of specialized training in working with individuals with mental health diagnoses. a. The training must be provided or approved by	AL243		

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AL243	Continued From page 42 the Department of Children and Families and must be taken within 6 months of the facility's receiving a limited mental health license or within 6 months of employment in a limited mental health facility. b. Training received under this subparagraph may count once for 6 of the 12 hours of continuing education required for administrators and managers pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 2. A minimum of 3 hours of continuing education, which may be provided by the ALF administrator, online, or through distance learning, biennially thereafter in subjects dealing with one or more of the following topics: a. Mental health diagnoses; and, b. Mental health treatment such as: (I) Mental health needs, services, behaviors and appropriate interventions; (II) Resident progress in achieving treatment goals; (III) How to recognize changes in the resident's status or condition that may affect other services received or may require intervention; and, ( ) Crisis services and the . . . . . procedures. 3. For administrators and managers, the continuing education requirement under this subsection will satisfy 3 of the 12 hours of continuing education required biennially pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 4. Administrators, managers and direct contact staff affected by the continuing education requirement under this subsection shall have up to 6 months after the effective date of this rule to meet the training requirement. (b) Administrators, managers and staff do not have to repeat the initial training should they	AL243		

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AL243	Continued From page 43 change employers provided they present a copy of their training certificate to the current employer for retention in the facility's personnel files. They must also ensure that copies of the continuing education training certificates, pursuant to subparagraph (a)2. of this subsection, are retained in their personnel files. This Statute or Rule is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that 2 of 6 sampled employees (A and C) received a minimum of 6 hours of specialized training in working with residents with mental health diagnoses. The findings included: A record review was conducted of employees A and C personnel files. Employee A hired on [redacted] and employee C hired [redacted]. The minimum 6 hours of specialized training in working with residents with mental health diagnoses was not found. On [redacted] at approximately 11:00 AM, an interview was conducted with the Director of Clinical Operations who reviewed the two personnel files and reviewed the electronic files, but was unable to find the 6 hours of specialized training in working with residents with mental health diagnoses. Class III	AL243		
AN278 SS=D	59A-36.022(3) FAC; 429.07 (3)(c)2, FS LNS - Records 59A-36.022	AN278		

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AN278	Continued From page 44 (3) RECORDS. (a) A record of all residents receiving limited nursing services and the type of services provided must be maintained at the facility. (b) Nursing progress notes must be maintained for each resident who receives limited nursing services. (c) A nursing assessment conducted at least monthly must be maintained on each resident who receives a limited nursing service. 429.07 (3)(c)2, FS A facility that is licensed to provide limited nursing services shall maintain a written progress report on each person who receives such nursing services. The report must describe the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health. This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain a nursing assessment conducted at least monthly on each resident who receives a limited nursing service (LNS) for 6 of 6 resident records reviewed, (residents #5, #8, #11, #13, #15, #16). The findings include: A record review was conducted for Resident #5. No monthly LNS assessments were found. A record review was conducted for Resident #13. No monthly LNS assessments were found. A record review was conducted for Residents #8, #11, #15, and #16. For the past 5 months, [redacted] and [redacted], the monthly	AN278		

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AN278	Continued From page 45 assessments were signed by a Licensed Practical Nurse instead of a Registered Nurse. An interview was conducted with the Operations Director, staff J, on [redacted] at approximately 3:00 PM. Staff J confirmed that the Limited Nursing Service (LNS) consultant procedure was for the LNS Registered Nurse (RN) contractor to co-sign the monthly LNS assessments. Staff J confirmed that there were no LNS co-signatures on the monthly nursing assessments for residents #8, #11, #15, and #16 for the months of [redacted] and [redacted]. Staff J stated, "I will look into that." Staff J nodded her [redacted] from front to [redacted] when presented with the LNS notebook and informed that no LNS monthly nursing assessments were found for resident # 5 and resident #13. As of [redacted] at 4:00 PM, no LNS monthly nursing assessments were provided for resident #5 and resident #13. An interview was conducted with the Limited Nursing Services (LNS) Registered Nursing Consultant on [redacted] at approximately 09:48 AM. The LNS Nurse Consultant stated that normally "...staff put them (monthly LNS assessments) in my box for co-sign." She stated that she has not received any LNS monthly assessments since [redacted]. She further stated that resident #13 "...is not my patient." Class III	AN278		
CZ814 SS=C	435.12(2)(b-d), FS Background Screening Clearinghouse	CZ814		

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CZ814	Continued From page 46 435.12(2) Care Provider Background Screening Clearinghouse.- (b) Until such time as the , , are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic , submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to maintain the employment status within the background screening clearinghouse for 2 of 6 sampled employees (employee D and F). The Findings included: On , , and , observations were made of employee D and F working in the	CZ814		

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CZ814	Continued From page 47 facility. A record review was conducted of the facility's employee roster to find both employee D and F listed. A review was conducted of the background screening clearinghouse roster and neither employee was included on the roster. Employee D was hired on and employee F hired in On at approximately 11:00 AM, an interview was conducted with the Director of Clinical Operations who stated that the previous administrator was supposed to keep up with employees status within the background screening clearinghouse. She stated that she was not aware that the background screening clearinghouse roster was not updated. Unclassified	CZ814		
CZ816 SS=C	408.809(2a-c) 435.05(2) 59A-35.090(2d-3c Background Screening-Compliance Attestation 408.809 Background screening; prohibited offenses.- (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	CZ816		

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CZ816	Continued From page 48	CZ816		

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 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

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CZ816	Continued From page 49 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. 435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers: (2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if for any of the disqualifying offenses while employed by the employer. 59A-35.090 Background Screening. (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	CZ816		

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CZ816	Continued From page 50 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 record review and staff interview, the facility failed to ensure that 1 of 6 sampled employees (employee E) Attestation of Compliance with Background Screening form was completed, signed and filed in the personnel file. The findings included: A record review was conducted of Employee E's personnel file to find the Attestation of	CZ816		

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CZ816	Continued From page 51 Compliance with Background Screening form blank. Employee E, a resident assistant, was hired on [redacted]. On [redacted] at approximately 11:00 AM, an interview was conducted with the Director of Clinical Operations who reviewed employee E's personnel file and confirmed that there was no completed Attestation of Compliance with Background Screening form in the file and she could not produce it. Class III	CZ816		
A 077 SS=G	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A new facility administrator must complete the required training and education, including the competency test, within 90 days after date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may	A 077		

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A 077	Continued From page 52 be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least [illegible]; 2. If employed on or after [illegible], have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to [illegible], are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances,	A 077		

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A 077	Continued From page 53 such as the . . . . . of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile . . . . . of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , . , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not . . . . . , serve as an administrator	A 077		

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A 077	Continued From page 54 of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility's administrator failed to ensure operation and maintenance of the facility. The administrator failed to ensure resident supervision and assistance for 3 of 16 residents, #2, #9 and #10. The administrator failed to ensure an activities program was being conducted for all 16 current residents. The administrator failed to honor residents rights for a decent living environment for all 16 current residents. The administrator failed to ensure staff had needed training, were free from communicable . . . . . and were added to the background screening clearinghouse roster. The administrator failed to investigate, implement corrective actions and report a resident elopement for 1 of 16 residents, #19. The demonstrator failed to ensure the facility maintained a copy of the current Comprehensive Emergency Management Plan and Emergency Power Plan and failed to ensure residents were informed of the plan for 2 of 2 resident records reviewed, (residents # 2, #5). The Administrator failed to ensure a Registered Nurse was conducting monthly assessments for the 6 residents identified as receiving Limited Nursing Services, #5, #8, #11, #13, #15, #16.	A 077		

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A 077	Continued From page 55	A 077		

The Findings included:

A0025: Based on observation and staff interview, the facility failed to provide personal supervision as appropriate for 2 of 16 residents reviewed (resident #9 and #10). Night shift staff failed to get up or check for resident elopement when the main entrance door alarm sounded. Night shift staff were unsure of resident room locations, and unable to demonstrate room checks being performed.

A0026: Based on observation, resident interview, staff interview and hospice staff interview, the facility failed to provide diversified individual and group activities and failed to demonstrate residents' participation in activities or activities planning. No activities were observed during the 4 days of the survey from [redacted] through [redacted]. Residents were observed unengaged, sitting with nothing to do and [redacted] aimlessly. An activities calendar was posted, but was not followed. This failure affected all 16 current residents including resident #5.

A0028: Based on observation and interview, the facility failed to provide supervision of or assistance with activities of daily living for 1 of 16 residents observed, (resident #2).

A0030: Based on observation and interviews, the facility failed to honor resident rights regarding a decent living environment for 1 of 16 residents reviewed (# 1). Resident #1's room had a strong, noxious [redacted] odor.

A0031: Based on staff interview and record review, the facility failed to ensure staff received training on the facility's resident elopement response policies and procedures. The facility

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A 077	Continued From page 56 failed to ensure staff were able to demonstrate competency in the implementation of the elopement response policies and procedures. This failure led to the facility staff being unaware of the elopement of Resident #19 in until reported by the store clerk and police. A0075: Based on observation of the facility's Automated External Defibrillator ( ) and interview with the facility's nursing staff, the facility failed to have an operational on premise for 1 of 1 's reviewed. A0078: Based on staff interview and record review, the facility failed to ensure that within 30 days newly hired staff submitted a written statement from a health care provider documenting that the employee does not have any signs or symptoms of communicable and evidence of a negative examination for 3 of 6 employees (D, E and F). A0081: Based on staff interview and record review, the facility failed to ensure that 2 of 6 sampled employees (D and E) received preservice orientation prior to interacting with residents. The facility failed to ensure that 1 of 6 sampled employees (employee D) who provides direct care received a minimum of 1 hour in-service within 30 days of employment that covers reporting major incidents, reporting adverse incidents, /neglect and nutritional and safe food training's. The facility also failed to ensure that 4 of 6 sampled employees (C, D, E and F) received in-service training regarding the facility's resident elopement response policies and procedures and the facility failed to ensure staff were able to demonstrate competency in the implementation of the elopement response policies and procedures.	A 077		

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A 077	Continued From page 57 A0082: Based on staff interview and record review, the facility failed to ensure that 1 of 6 sampled employee (employee D) completed a one time education course on [redacted] within 30 days of employment. A0090: Based on staff interview and record review, the facility failed to ensure that 1 of 6 sampled employees (employee D) received at least one hour of training in the facility's policies and procedures regarding [redacted]. A0152: Based on observation and staff interview, the facility failed to provide a safe living environment, free of hazards, and ensuring that all structural systems are in good working order, including resident's bathrooms. This effected the lobby area, the hallway 1600, resident #2's heating unit, resident #13's bathroom sink and shower and resident #15's shower for hot water. A0161: Based on staff interview and personnel record review, the facility failed to ensure that 1 of 6 sampled employee's (employee E) personnel file contained a copy of the employment application with references. The facility also failed to ensure that 3 of 6 employee's personnel files (D, E and F) contained documentation verifying freedom from signs of symptoms of communicable and evidence of negative [redacted]. The facility also failed to ensure that 6 of 6 personnel files (A, B, C, D, E and F) contained documentation verifying participation in resident's elopement drills. A0200: Based on observation, record review,	A 077		

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A 077	Continued From page 58 and staff interview, the facility failed to maintain a copy of its approved Comprehensive Emergency Management Plan (CEMP), failed to immediately produce the plan, either in electronic or paper format, upon request, and failed to immediately produce the CEMP notifications provided to each resident and the resident's legal representative, either in electronic or paper format for 2 of 2 resident records reviewed, (residents # 2, #5). L243: Based on staff interview and record review, the facility failed to ensure that 2 of 6 sampled employees (A and C) received a minimum of 6 hours of specialized training in working with residents with mental health diagnoses. N278: Based on record review and staff interview, the facility failed to maintain a nursing assessment conducted at least monthly on each resident who receives a limited nursing service (LNS) for 6 of 6 resident records reviewed, (residents #5, #8, #11, #13, #15, #16). Z814: Based on observation, staff interview and record review, the facility failed to maintain the employment status within the background screening clearinghouse for 2 of 6 sampled employees (employee D and F). Z816: Based on record review and staff interview, the facility failed to ensure that 1 of 6 sampled employees (employee E) Attestation of Compliance with Background Screening form was completed, signed and filed in the personnel file. Class II	A 077		

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A 078	Continued From page 59	A 078		
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 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	A 078		

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A 078	Continued From page 60 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 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 staff interview and record review, the facility failed to ensure that within 30 days newly hired staff submitted a written statement from a health care provider documenting that the employee does not have any signs or symptoms of communicable and evidence of a negative . . . . . examination for 3 of 6 employees (D, E and F). The Findings include: A record review was conducted of employee D, E	A 078		

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A 078	Continued From page 61 and F's personnel files to find the following: A record review of Employee D's personnel file was conducted. Employee D was hired on . Record review found no written statement from a health care provider documenting that the employee does not have any signs or symptoms of communicable and no evidence of a negative examination. A record review of Employee E's personnel file was conducted. Employee E was hired on . Record review found no written statement from a health care provider documenting that the employee does not have any signs or symptoms of communicable and no evidence of a negative examination. Employee F was hired in and record review of the personnel file found no written statement from a health care provider documenting that the employee does not have any signs or symptoms of communicable and no evidence of a negative examination. On at approximately 11:00 AM, an interview was conducted with the Director of Clinical Operations who reported that it was the responsibility of the previous Executive Director to ensure that all documentation were in the employees files. The Director of Clinical Operations reviewed the files and confirmed that each of the employees were missing the written statement from a health care provider that the employee does not have any signs or symptoms of communicable and evidence of a negative examination	A 078		

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A 078	Continued From page 62 Class III	A 078		
A 081 SS=G	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	A 081		

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A 081	Continued From page 63 29 CFR 1910.1030, relating to . . . . borne , , 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 , 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.	A 081		

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A 081	Continued From page 64 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: Based on staff interview and record review, the facility failed to ensure that 2 of 6 sampled employees (D and E) received preservice orientation prior to interacting with residents. The facility failed to ensure that 1 of 6 sampled employees (employee D) who provides direct care received a minimum of 1 hour in-service within 30 days of employment that covers reporting major incidents, reporting adverse incidents, [redacted]/neglect and nutritional and safe food training's. The facility also failed to ensure that 4 of 6 sampled employees (C, D, E and F) received in-service training regarding the facility's resident elopement response policies and procedures and the facility failed to ensure staff were able to demonstrate competency in the implementation of the elopement response policies and procedures. The findings include: A record review was conducted of employee D and E personnel files. There was no evidence that the required 2 hours of preservice orientation had been conducted prior to interacting with residents. A continued review of employee D's personnel file failed to find a minimum 1 hour in-service within 30 days of employment that covered reporting major incidents, reporting adverse incidents,	A 081		

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A 081	Continued From page 65 /neglect and nutritional and safe food training's. A record review for elopement training was conducted for employees C, D, E and F. There was incomplete evidence regarding elopement training. The elopement form did not identify names of staff receiving training. There was no evidence that the facility evaluated the employees competence in implementing elopement policies. Employee C, a resident assistant, was hired . Employee C was promoted to Activity Director on . Employee D, a resident assistant, was hired on . Employee E, a resident assistant, was hired on . Employee F, a resident assistant, was hired . On at approximately 9:09 AM, an interview was conducted with Employee C. Employee C was asked if the facility conducted elopement drills and how many had he participated in? Employee C reported that the facility had not conducted elopement drills. Employee C related an incident in where a resident eloped next door to a convenient store and threatened the store clerk to rob the store for cigarettes. The store clerk called law enforcement and the facility and the resident was taken to the behavioral center for assessment. Employee C reported that staff did not receive elopement training after this elopement. On at approximately 9:56, an interview was conducted with Employee D. Employee D	A 081		

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A 081	Continued From page 66 was asked if the facility conducted elopement drills and how many had he participated in? Employee D reported that he had not participated in any elopement drills, nor had the facility provided training. Employee D confirmed that after the elopement in , where a resident eloped from the facility to convenient store next door and tried to rob the store, he had not received elopement training. On at approximately 2:46 PM, an interview was conducted with Employee F. Employee F was asked if the facility conducted elopement drills and how many had she participated in? Employee F reported that she had not participated in any elopement drills since she been working at the facility. On at approximately 1:00 PM, a telephone interview was conducted with Employee E. Employee E was asked if the facility conducted elopement drills and how many had she participated in? Employee E reported she had not received elopement training and the facility still had not provided elopement training even after a resident eloped from the facility. On at approximately 11:00 AM, an interview was conducted with Director of Clinical Operations to request documentation for elopement drills conducted by the facility. The Director of Clinical Operations provided three elopement drills dated (, , and). The elopement drills did not include any employee's names who had participated in the elopement drill. When the Director of Clinical Operations was asked to produced names of staff who had participated in elopement drills, she reported that she could not produce the documentation because the previous executive	A 081		

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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 081	Continued From page 67 director was not a good record keeper. Class II	A 081		
A 082 SS=D	59A-36.011(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 maintained in accordance with subsection (12), of this rule. This Statute or Rule is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that 1 of 6 sampled employees (employee D) completed a one time education course on / , (/) within 30 days of employment. The findings included: A record review was conducted of employee D's personnel file. Employee D was hired on . Review of the personnel file found no evidence of the one time education course on / (/). On at approximately 11:00 AM, an interview was conducted with the Director of	A 082		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965645	A. BUILDING: _____ B. WING _____	01/30/2020

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A 082	Continued From page 68 Clinical Operations who reviewed the personnel file and confirmed that the / one time education course was not in the personnel file. Stated that she was not able to produce the one time education course on / . . . Class III	A 082		
A 090 SS=D	59A-36.011(11) FAC Training - . . . (11) . . . TRAINING. (a) 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 . (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 staff interview and record review, the facility failed to ensure that 1 of 6 sampled employees (employee D) received at least one hour of training in the facility's policies and procedures regarding . . . . . . The Findings included: A record review was conducted of employee D's personnel file. There was no evidence of the required one hour of training in the facility's	A 090		

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
	AL11965645	A. BUILDING: _____ B. WING _____	01/30/2020

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A 090	Continued From page 69 policies and procedures regarding . . . . . ( ). Staff D, a resident assistant, was hired on . . . . . On . . . . . at approximately 11:00 AM, an interview was conducted with the Director of Clinical Operations who reviewed employee D's personnel file and verified that the training was not in the personnel file. She stated that the training could not be produced. Class III	A 090		