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
	AL11966003	A. BUILDING: _____ B. WING _____	02/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SARA HOME CARE	29100 SW 172 AVENUE HOMESTEAD, FL 33030

(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 000	Initial Comments AMENDED A complaint investigation (complaint number 2020002505) was conducted at Sara Home Care on . . . . . and concluded on . . . . . . Deficiencies were identified at the time of the survey.	A 000		
A 010 SS=G	429.26(&9) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination shall be based upon an assessment of the strengths, needs, and preferences of the resident, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (2) A physician, physician assistant, or nurse practitioner who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interest in the facility.	A 010		

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

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

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A 010	Continued From page 3 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the appropriateness of continued residency of one out of 15 sampled residents (Resident #1). Resident #1 exhibited changes in behavior including and trespassing onto a neighbor's property for at least three months, stealing from other residents and staff, verbally assaulting staff, and not complying with his medication regimen. Findings included: A review of incident reports on showed six for Resident #1 during . First, on , Resident #1 went onto the neighbors property without consent. The second incident happened on when the resident from the facility into the surrounding area without staff knowledge of his whereabouts. The third incident was on when Resident #1 eloped. The fourth incident was on when the resident left the facility again without informing anyone. The fifth incident was on when Resident#1 went to church and did not return; later brought to facility by law enforcement. On the resident returned with dirty clothes and on his arms. According to the reports, Resident #1 explained to Staff B on that he while was out. The last incident on showed Resident #1 from the facility the night before. A local and notified the staff that Resident #1 was in the emergency room after being found incoherent on a busy street intersection by the police. In an interview on at 7:06 AM, Staff C stated that Resident #1 caused problems lately.	A 010		

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A 010	Continued From page 4 In an interview on at 8:09 AM, Staff B stated that Resident #1 knocked on a neighbor's house door in the middle of the night after he'd gone out to buy cigarettes. The facility did not know at what time he left. In an interview on at 2:52 PM, Neighbor #1 stated that she saw Resident #1 looking through the windows of her home at 2:33 AM on . . . . . and looking under the flowerpots for a key to enter. The neighbor also stated that she felt afraid, and that if the resident did get inside of her house, she would shoot him. On at 9:48 AM, Staff B, the owner, stated that Resident #1 left the facility during the night shift on but the staff did not know exactly when. Review of progress notes for Resident #1 showed that the resident from the facility during the night shift on . . . . . There was no documentation of intervention. Further review showed no documentation of consultation with the resident's health care provider regarding the need for intervention. In an interview on . . . . . at 7:11 AM, Staff D stated that Resident #1 from the facility during the weekend and the facility called law enforcement. On further interview at 8:00 AM, Staff D added that Resident #1 . . . . . from the facility the afternoon of . . The staff called the administrator who instructed her to wait and see if the resident returned. The staff called the police and they brought Resident #1 . . . to the facility"like every day". Staff D added, at 8:12 AM on . . . . around 2:00 AM Resident #1 again from the facility. The resident	A 010		

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A 010	Continued From page 5 was impatience, [redacted], continuously moved around, talking with a rude tone to everyone and threatening staff with [redacted] outside of the facility. Resident #1 [redacted] from the facility also on [redacted] during the night shift, around 8:00 PM. The staff did not know where Resident #1 was after he [redacted] from the facility. In an interview on [redacted] at 8:29 AM, Staff G stated that the police went to the facility on [redacted] because they wanted to speak to Resident #1. The staff stated that she assumed that the conversation between the police and Resident #1 was because one neighbor called the police. Since [redacted] the resident became verbally offensive and started screaming to the staff . The facility also noted that other residents' belongings was missing from their rooms and the staff found those belongings in Resident #1's room. The facility's staff found Resident #1 looking in Staff E's purse. In an interview on [redacted] at 8:29 AM, Staff G stated that Resident #1 smelled of [redacted] when the police brought him [redacted] on [redacted]. The resident told the staff that he had drank some beers with someone that he knew. Review of police reports showed that the facility contacted the police on [redacted] at 9:16 PM because Resident #1 was missing from the facility. The police found him and when they returned him to the facility, the staff on duty advised the police that "for the past few days Resident had been running away from the ALF and has almost placed himself in front of vehicles on purpose." The police report further stated "The patient has entered stranger vehicles and has been transported to other locations." The resident was hospitalized under [redacted].	A 010		

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A 010	Continued From page 6 Review of police reports showed that the facility contacted the police on [redacted] at 1 PM because Resident #1 was missing from the facility. Staff B found Resident #1 approximately 2 miles away from the facility. Staff B and one other staff advised the police that Resident #1 was "acting up and causing issues in the ALF" (Assisted Living Facility). Review of progress notes for Resident #1 showed that there was no documentation that the facility informed the Resident #1's doctor, or that a doctor evaluated him regarding the ongoing problems. Review of the photo provided by Neighbor #1 showed that Resident #1 was on her property. Reviewed copies of letters, police reports and photographs of residents on neighbor property for at least the last six months provided by one of the neighbors The documents showed that neighbors contacted the facility's owner and made him aware of the Residents issues. The neighbor had delivered the concerns in writing by registered mail to the facility and emails sent to the facility's owner, The most recent photo was two weeks before the investigation. Review of Resident #1's record showed that there was a health assessment completed on [redacted]. The assessment indicated Resident #1 who has medical history and diagnoses of [redacted] type II, high [redacted], low energy, [redacted], and [redacted] at times, needed assistance with self-administration of medication.	A 010		

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A 010	Continued From page 7 Observation on [illegible] at 8:53 AM, reconciliation of medications for Resident #1 showed that there was a medication bin with the resident's name and medication bottles inside. - There was one bottle of [illegible] (use to treat high [illegible] levels in [illegible]) 600 mg tablet which the pharmacy filled on [illegible] with 60 tablets and still had approximately 80% of the pills inside of it. The medication had instructions to take one tablet by [illegible] twice. - There was one bottle of [illegible] 300 mg tablet which the pharmacy filled on [illegible] with 60 tablets and still had approximately 75% of the pills inside of it. The medication had instructions to take one tablet by [illegible] twice a day. According to the National Alliance on Mental Illness, [illegible], was a medication used to treat [illegible], by improving thinking, [illegible] and behaviors. The FDA (Food Drug Administration) approved the use of the medication for the treatment of [illegible] and [illegible], episodes of [illegible], Missing doses of [illegible], may increase the risk for a relapse in the symptoms. - There was one bottle of [illegible] 50 mg tablet which the pharmacy filled on [illegible] with 30 tablets and still had approximately 25% of the pills inside of it. The medication had instructions to take one tablet at bedtime. Review of Medication Observation Records for Resident #1 showed that there was no documentation explaining the extra doses of the medications that remained in the bottles. Class II	A 010		

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A 025	Continued From page 8	A 025		
A 025 SS=J	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 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.	A 025		

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A 025	Continued From page 9 (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, record review and interview, the facility failed to provide adequate supervision, care and services for 10 out of 15 sampled residents (#1, #2, #4, #5, #6, #7, #8, #9, #10 and #11). Two residents eloped from the facility since (Residents #1 and #13). Resident #1 eloped at least on five different occasions during and trespassed on the neighbor's property. Facility's neighbors threatened to shoot residents who showed up on their property during the night. Resident # 13 eloped and has never been located. Multiple residents have been hospitalized under (#1, #3, #12, #5 and #14) two of whom assaulted staff and threatened peers (#6 and #12) and others who were (#5, #14, and #12). The facility did not maintain general awareness of the resident's whereabouts for four out of 15 sampled residents (#1, #2, #4 and #13). The facility failed to maintain an updated written record for two out of 15 sampled residents (#3 and #5). Findings included: 1. Observation on at 6:40 AM showed that Resident #9 opened the front door of the facility while Staff C was in the kitchen. Staff C was at the facility alone taking care of 10	A 025		

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A 025	Continued From page 10 residents. On . . . . . at 6:50 AM, Staff C stated that she worked every day from 6 PM to 7 AM. On at 9:46 AM, Staff B, the owner, stated the facility did not have a problem with supervision and that residents were free to go in and out of the facility. Observation on . . . . . at 6:12 AM showed that Resident #2 opened the front door of the facility while Staff F was on the . . . porch . Staff F was on duty alone, taking care of 10 residents (#1, #2, #4, #5, #6, #7, #8, #9, #10 and #11). On at 6:12 AM, Staff F stated that she did not provide care to the residents, she just did laundry and housekeeping. Staff F further stated that Staff E had left but would be soon, because she went to her house to wake up a family member. On at 7:41 AM, Resident #11 stated that Staff C or F worked at the facility during the night. A review of Staff F's records showed that her job application was dated . There was no documentation that Staff F had First Aid and , , ( ) training. A review of facility records showed no staff on duty from 6 PM to the following day at 8 AM on Saturdays and Sundays . In an interview on at 9:48 AM (three days after inadequate supervision was identified), Staff B again stated that the facility did not implement any new measures because the facility did not have a problem providing supervision to	A 025		

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A 025	Continued From page 11 the residents. Staff B added that the residents were free to go in and out of the facility. 2. Review of adverse incidents on showed six reports for Resident #1 on . The first incident happened on when Resident #1 went onto the facility's neighbor property. The second incident happened on when the resident from the facility. The third incident was on when Resident #1 eloped from the facility. The fourth incident was on when the resident left the facility without informing anyone. The fifth incident was on when Resident#1 went to church and did not return; later brought to facility by law enforcement. On the resident returned with dirty clothes and on his arms. Resident #1 explained to Staff B on that he while was out of the facility. The last incident reported was on showed Resident #1 from the facility the night before. A local hospital contacted the facility and notified them about having Resident #1 in the emergency room after being found incoherent on a busy street intersection by the police. In an interview on at 8:09 AM, Staff B stated that Resident #1 knocked on one of the neighbor's house door in the middle of the night. The resident went out to buy cigarettes. The facility did not know at what time he left. Observation on at 6:09 AM showed no lights and in front of the facility and the facility was dark. In an interview on at 9:48 AM, Staff B, the owner, stated that Resident #1 left the facility during the night shift on but the staff did	A 025		

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A 025	Continued From page 12 not know exactly when. In an interview on [redacted] at 2:52 PM, Neighbor #1 stated that Resident #1 was on her property looking through the windows at 2:33 AM on [redacted] and looking under the flowerpots for a key to enter. The neighbor also stated not feeling secure and further stated that if the resident did get inside of her house, she would shoot him. Neighbor #1 explained that the situation happened over a period of at least six months, with different residents. In an interview on [redacted] at 3:27 PM, Neighbor #2 stated that automobile's traffic was at speed between 70 and 80 miles per hour on that dark street where the facility was located. The neighbor expressed concerns about the residents walking on dark streets during night hours because they were at risk to be hit by automobile's. Review of the doorbell camera video, provided by Neighbor #1, showed that Resident #1 was on her property (photographic evidence obtained). Review of copies of letters, police reports and photographs of residents on the neighbor's property for at least the last six months, documents provided by one of the neighbors, showed that the neighbors contacted the facility's owner and made him aware of the Residents issues. The neighbor had delivered the concerns in writing by registered mail to the facility and emails sent to the facility's owner, the most recent photo was two weeks before the investigation. Review of progress notes for Resident #1 showed that the resident [redacted] from the facility during the night shift on [redacted].	A 025		

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A 025	Continued From page 13 In an interview on at 7:11 AM, Staff D stated that Resident #1 from the facility during the weekend (, , and ,) and the facility staff called law enforcement. According to the staff, Resident #1 from the facility on multiple occasions and different times of the day and night. The staff on duty called law enforcement numerous times when Resident went missing from the facility and the police brought Resident #1 "like every day". The staff did not know where Resident #1 was when he from the facility. In an interview on at 8:29 AM, Staff G stated that Resident #1 became verbally offensive and started screaming to the staff since . The facility also noted that other residents' belongings was missing from their rooms and the staff found those belongings in Resident #1's room. The facility's staff found Resident #1 looking in Staff E's purse. Staff G also stated that Resident #1 smelled of when the police brought him on . Review of police reports in reference to the facility's address showed that the facility contacted the police at least on two different occasions during , related to Resident #1 being missing from the facility. The first call was on at 9:16 PM, staff on duty talked to the police and when resident was found he was brought to the facility. The staff on duty advised the police that "for the past few days Resident #1 has been running away from the facility and has almost placed himself in front of vehicles on purpose." The police report further stated "The patient has entered stranger vehicles and has been transported to other locations." The resident was hospitalized under . The	A 025		

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	AL11966003	A. BUILDING: _____ B. WING _____	02/29/2020

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A 025	Continued From page 14 facility also called the police on [redacted] at 1:00 PM because Resident #1 was missing from the facility. Staff B found Resident #1 approximately 2 miles away from the facility. Staff B and another staff advised the police that Resident #1 was "acting up and causing issues in the facility. Review of Resident #1's record showed that there was a [redacted] health assessment completed on [redacted]. The assessment indicated Resident #1 had a medical history and diagnoses of [redacted] type II, high [redacted], low energy, [redacted] and [redacted] at times. There was no documentation that the facility informed the Resident #1's doctor, or that a doctor evaluated him regarding the ongoing problems. Review of police report showed that the facility contacted the police on [redacted] at 7:36 AM because Resident #13 was missing from the facility since [redacted]. The resident walked out of the facility on [redacted] at approximately 7:15 PM and never returned. The facility admitted the resident on [redacted] around noon after he had been hospitalized for 66 days in a crisis unit at a local hospital. The staff advised the police that the resident suffered from "unknown mental condition" and that the court system placed the resident in the facility. The police investigator found out a month later that the resident violated the terms placed by the court when he left the facility. The court issued an alias capias warrant on [redacted]. Review of Neighbor #1's statement revealed that on the afternoon of [redacted], one of the residents from the facility was on her property. The neighbor stated that she sent the video to Staff B	A 025		

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A 025	Continued From page 15 whom never replied to her about it. In an interview on [redacted] at 9:43 AM, Staff B stated a resident went to the facility's neighbor house and knocked on the door sometime in 2019. The staff informed that the resident was a new admission to the facility who went out to buy cigarettes and got lost. Staff B stated that he did not remember the name of the resident or the date of the incident. On a further interview at 9:48 AM, Staff B stated that the facility had not implemented any measures to prevent further incidents of Residents going to the neighbors houses because the neighbors complained about everything related to the facility. Review of police report showed that the facility contacted the police on [redacted] at 5 PM because Resident #15 was missing from the facility. According to the police report the resident left the facility around 2:00 PM and did not return. The staff on duty reported to the police officer that Resident #15 left the facility every day but for short periods of time and that the resident suffered from [redacted]. Review of the facility's record showed there was no documentation of when Resident #15 returned to the facility or when the Resident left again. Review of the admission and discharged log showed that Resident #15's discharge date was on [redacted]. The reason for discharge; resident was in violation of probation and Resident #15 went to jail. Review of Neighbor #1's documented information showed that she wrote a letter to Staff B and to the facility on [redacted]. The letter showed Neighbor #1 informed the facility that residents	A 025		

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A 025	Continued From page 16 from the facility trespassed on her property on multiple occasions. In an interview with the neighbor she stated, the facility's owner did not take any actions to resolve the issues of residents [illegible] on her property. Neighbor #1 expressed being concern for her personal safety. The Neighbor #1 stated on [illegible] a resident from the facility was in her driveway, [illegible] and fully exposing his [illegible]. Neighbor #1 stated she had sent a text to Staff B informing him of the Resident behavior, and Staff B replied, that the neighbor did not have any evidence. Review of Neighbor #2's email sent to Staff B on [illegible] showed the neighbor informing Staff B about an incident she witnessed with one of the facility's resident at Neighbor #1's property. Neighbor #2 stated that the facility was located in a very small neighborhood where they knew each other. The neighbor indicated that on around 5:20 PM she saw a resident from the facility standing in Neighbor #1's driveway, [illegible] on the lawn completely exposing his [illegible]. 3. Review of records for Resident #1 showed that he was hospitalized under [illegible] on [illegible] and on [illegible] for problems with behavior. Review of Resident #3's record showed that there were hospital discharge papers for [illegible]. The discharge summary indicated, under the chief complaint, Resident #3 was hospitalized under [illegible] after being disorganized and aggressive towards others at the ALF (Assisted Living Facility) where he lived. The resident was [illegible] and noncompliant with medical treatment. Review of police report showed that Resident #12	A 025		

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A 025	Continued From page 17 was hospitalized under . . . . on . . . and on . Review of police report showed that Resident #5 was hospitalized under . . . . on . . . . . . Review of police report showed that Resident #14 was hospitalized under on . 4. Observation on at 6:50 AM and at 8:31 AM showed Resident #6 sat in the living room. The resident pulled up his T-shirt, covered his . . . while he made loud noises and screamed repeatedly. Resident # 9 redirected Resident #6 on both occasions when Resident #9 said that he was going to call the police if Resident #6 did not stop making those noises. Observation on . . . . . at 6:12 AM and 7:31 AM showed Resident #6 sat in the living room while he pulled up his T-shirt, covered his . . . while he made loud noises and screamed repeatedly. Resident # 9 redirected Resident #6 to stop making those noise. Observed that there was no intervention or assistance provided by the staff. Review of Resident #6's record showed that that there were discharge papers from the hospital. The resident received care at a local hospital for , . , ... while he was hospitalized from to . The resident received care at a local hospital for , . , ... while he was hospitalized from to . The hospital record showed that , . , . . . was a severe loss of contact with reality. People who had , . , . . . were not able to think clearly and their emotions and responses did not match with what actually happened making them to be very upset and have chaotic behaviors. The , ,	A 025		

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A 025	Continued From page 18 can be caused by , , conditions, such as , , , or major . Review of progress notes for Resident #6 showed that on the facility called the ambulance to transfer resident to the hospital. The facility sent the resident to the hospital for an evaluation because he was very aggressive, screaming and did not sleep. The facility decided to send the resident to the hospital on because he was very aggressive. In an interview on at 8:52 AM, Staff G stated that the progress note for Resident #6 documented on happed on . The resident hit the staff on and . On further interview at 8:54 AM, Staff G stated that Resident #6 was at the hospital for more or less one week or ten days on and then again on , for one week to ten days. Staff G also stated that Resident #6 did not present any changes and it was normal for him to scream. Review of progress notes for Resident #6 completed on indicated that the resident was aggressive with the staff. The resident did not allow staff to touch him, did not want to bath or change clothes and kept screaming the whole day since them. In an interview on at 8:51 AM, Staff G stated that Resident #6 hit the staff on . Review of the facility's record and Resident #6's record showed that there was no documentation that his health care provider had been notified. Review of police reports showed that the facility	A 025		

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A 025	Continued From page 19 contacted the police on [redacted] at 2:36 PM because Resident #12 was violent and made threats to staff. The resident went into other residents and staff members' faces, threatening them. The residents and staff members locked themselves in the resident's rooms or the office because of Resident #12's behavior. The staff advised the police "Resident #12 does take medications for [redacted] but the staff was not sure if he took them today". The resident was hospitalized under [redacted]. 5. Review of a police report showed that Resident #5 contacted the police on [redacted] at 11:49 AM because he wanted to be hospitalized under [redacted]. The resident advised the police at arrival to the facility that he suffered from [redacted], and [redacted]. Resident #5 stated that he had [redacted] thoughts and was going to overdose on prescription medication to kill himself. The resident was hospitalized under [redacted]. Review of progress notes for Resident #5 did not show any documentation of any incident with the Resident #5 on [redacted]. There was no documentation indicating that the resident showed or expressed any [redacted] thoughts. There was no documentation that the resident went to the hospital or that the police placed him under the [redacted]. Review of a police report showed that the facility contacted the police on [redacted] at 12:53 PM because Resident #14 had a medical episode. The resident needed to attend a court ordered [redacted], but he refused to go. The police observed that the resident was "very agitated and causing other residents to be upset". The police report revealed that the resident wanted the	A 025		

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A 025	Continued From page 20 police to give him the police's gun "so he could blow his brains out". Resident #14 told police "he did not want to live anymore". The resident was hospitalized under . Review of police report showed that the facility contacted the police on at 5:16 PM because Resident #12 was in crisis. The resident was outside in the rear yelling and screaming that he was shot in the of the and wanted to go to see his father. The resident was disoriented to time, place and person. The resident was hospitalized under . 6. Observation on at 6:40 AM revealed that Resident #2 was at the facility. Further observation on at 9:14 AM showed that Resident #2 was not at the facility. In an interview on at 9:37 AM, Staff D stated not knowing that Resident #2 was at the facility. She would find out about him. On further interview at 9:38 AM, the staff stated that she assumed Resident #2 went to local program, but they were not sure. The staff did not know the name of the program that the resident attended. Observation on at 9:15 AM during reconciliation of medications for Resident #2 showed that there was medication bin with the resident's name and medication bottles inside. There was one bottle for Resident #2 of , 250 mg DR tab tablet with instructions to take three tablets by two times a day. The pharmacy filled the medication bottle on with 180 tablets. The bottle still had around 60% of the pills inside. There was one bottle for Resident #2 of , 4 mg tablet with instructions to take one tablet by at bedtime. The pharmacy filled the medication	A 025		

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A 025	Continued From page 21 bottle on [redacted] with 30 tablets. The bottle still had around 50 % of the pills inside, more than 12 tablets. There was one bottle for Resident #2 of [redacted] 300 mg capsules with instructions to take one capsule by [redacted] three times a day. The pharmacy filled the medication bottle on [redacted] with 90 capsules. The bottle still had around 60% of the capsules inside. There was one bottle for Resident #2 of [redacted] 2 mg tablet with instructions to take one tablet by [redacted] every day. The pharmacy filled the medication bottle on [redacted] with 30 tablets. The bottle still had around 50 % of the pills inside, more than 19 tablets. Review of the Medication Observation Records (MOR) for Resident #2 showed that he was prescribed [redacted], and [redacted] used to treat [redacted] is used to treat [redacted] and irritability related to [redacted] is used to treat [redacted], or [redacted]. Review of Resident #2's record showed that there was a health assessment (AHCA form 1823) completed on [redacted]. The resident had medical history and diagnoses of [redacted], cigarette [redacted] dependence, mild [redacted] and [redacted]. The assessment showed that the resident needed help taking his medications and the resident needed to be reminded and monitored medication intake. There was a court involuntary outpatient placement and continued involuntary outpatient placement on file dated [redacted] for Resident #2. The court document indicated that the resident had [redacted], non-compliance with medications, poor insight and judgment, [redacted] and	A 025		

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A 025	Continued From page 22 responding to internal stimuli. Review of progress notes for Resident #2 record showed that the facility gave his medications to the resident when he said that he was going home with his family ( ). Review of Resident #2's record showed that the resident did not have any family listed on his record. In an interview completed on at 8:37 AM, Staff G stated not knowing of Resident #2's whereabouts when he left on . Observation on at 8 AM, 8:25 AM, and 9:30 AM showed Resident #4 asking repeatedly to go to church. Staff D answered to resident on the different occasions that it was Saturday and there was no church service on Saturdays. In an interview on at 8:17 AM, Staff B stated that none of the residents were a risk for elopement. In an interview on at 9:30 AM, Staff D stated that Resident #4 liked to go church. The staff added that Resident #4 went frequent to church with other residents but without any staff. In an interview on at 6:26 AM, Resident #4 stated that he liked to go church. The resident stated that he did not have an identification with him or anything that showed the facility's address or the facility's telephone number. The resident did not know the facility's telephone number. Review of Resident #4's record showed that there was a health assessment (AHCA form 1823) completed on . The resident had medical history and diagnoses of , , depress , lack of energy and	A 025		

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A 025	Continued From page 23 identified as an elopement risk. Observation on at 10:40 AM showed that the church where Resident #4 went was about half a mile from the facility. In an interview on at 10:47 AM, the pastor from the church stated that Resident #4 went to church frequently. The resident went to church service on Sundays but also other days during the week. 7. In an interview on at 9:33 AM, Staff E stated that Resident #3 was at a local hospital since for aggressive behavior. The information should be on his record. Review of Resident #3's record on showed that there was no documentation showing when he went to the hospital or the reason for the hospitalization. In an interview on at 8:42 AM, Staff E stated, "Resident #3 is out since, let me look, . The doctor called because he needed higher supervision". Review of progress notes for Resident #3 on showed that the facility called emergency services on around 5 PM because the resident on the porch. The ambulance did not transfer the resident to the hospital on ; the resident stayed in the facility. Review of progress notes for Resident #3 on at 8:45 AM showed that the facility called the ambulance on around 10:30 AM because the resident had difficulties walking. The resident's primary care physician would	A 025		

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A 025	Continued From page 24 check on him at the hospital. Review of Resident #3's record on showed that there was a discharge summary from the hospital indicating he stayed at the hospital from to . The summary indicated under the chief complaint that Resident #3 was backer acted after being disorganized and aggressive towards others at the ALF (Assisted Living Facility) where he lived. The resident was and noncompliant with medical treatment. Review of progress notes for Resident #3 on showed that the facility sent Resident #3 to the hospital on because he had difficulties walking, was , and . Observation on at 9:11 AM during reconciliation of medications for Resident #5 showed that there was a medication bin with the resident's name and medication bottles inside. There was one bottle for Resident #5 of , 300 mg tablet with instructions to take one tablet by three times a day. The pharmacy filled the medication bottle on with 90 tablets. The bottle still had around 60% of the pills inside. Review of Resident #5's MOR for , showed he was not in compliance with his medications for several days in , . The resident did not take the 2:00 PM dose of , 300 mg which was used to treat changes and , for seven days. Resident #5 did not take the 2:00 PM dose of Ultra 125 mg which was used to treat fungal for 5 days the 8:00 PM dose one time.	A 025		

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A 025	Continued From page 25 Review of Resident #5's record showed that there was a health assessment completed on . The assessment indicated Resident #5 who has medical history and diagnoses of , , ( ), , and memory loss, needed assistance with self-administration of medication. There was no documentation explaining why there was extra amount of medications remaining for Resident #5. Class I	A 025		
A 027 SS=G	59A-36.007(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making , , and remind residents about scheduled , , for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation. (c) The facility may not require residents to receive services from a , health care provider. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to assist and ensure that two out of 15 sampled residents received the medical care needed (#1 and #9). Resident #1 exhibited changes in his behaviors since , including stealing from other residents and staff	A 027		

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A 027	Continued From page 26 and cursing at the staff. Resident #1 was not in compliance with the medication treatment and from the facility at least on six different occasions during Findings included: Facility record review on showed six adverse incidents reports for Resident #1 in when the resident away without staff knowing his whereabouts on and . Review of police report related to the call placed by the facility on at 9:16 PM because Resident #1 missing from the facility showed that the resident was hospitalized under . The staff on duty advised the police that "for the past few days resident has been running away from the facility and has almost placed himself in front of vehicles on purpose." The police report further stated "The patient has entered stranger vehicles and has been transported to other locations." Review of police reports showed that the facility contacted the police on at 1:00 PM because Resident #1 was missing from the facility. Staff B found Resident #1 approximately 2 miles away from the facility. Staff B and one other staff advised the police that Resident #1 was "acting up and causing issues in the ALF" (Assisted Living Facility). Review of Resident #1's record showed the admission date to the facility was on . A health assessment completed on showed medical history and diagnoses of type II, high	A 027		

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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 027	Continued From page 27 , low energy, , and at times. The resident needed assistance with self-administration of medication. Review of progress notes for Resident #1 showed that there was no documentation that the facility informed the Resident #1's doctor, or that a doctor evaluated him regarding the ongoing problems. Observation on at 8:53 AM during reconciliation of medications for Resident #1 showed that there was a medication bin with the resident's name and medication bottles inside. - There was one bottle of (use to treat high levels in) 600 mg tablet which the pharmacy filled on with 60 tablets and still had approximately 80% of the pills inside of it. The medication had instructions to take one tablet by twice. - There was one bottle of 300 mg tablet which the pharmacy filled on with 60 tablets and still had approximately 75% of the pills inside of it. The medication had instructions to take one tablet by twice. - There was one bottle of 50 mg tablet which the pharmacy filled on with 30 tablets and still had approximately 25% of the pills inside of it. The medication had instructions to take one tablet at bedtime. Review of Medication Observation Records for Resident #1 and the resident's record showed that there was no documentation explaining the extra doses of the medications or that the resident's primary care physician was informed.	A 027		

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	AL11966003	A. BUILDING: _____ B. WING _____	02/29/2020

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A 027	Continued From page 28 Class II	A 027		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, including an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer, from where it is stored, and bringing it to the resident. (b) In the presence of the resident, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (h) Using a to perform -level checks. (i) Assisting with putting on and taking off stockings. (j) Assisting with applying and removing an but not with titrating the	A 052		

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A 052	Continued From page 29 prescribed [illegible] settings. (k) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device. (l) Assisting with measuring vital signs. (m) Assisting with [illegible] bags. (4) Assistance with self-administration does not include: (a) Mixing, [illegible], converting, or [illegible] medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a [illegible] of the body. (d) Administration of [illegible] preparations. (e) Irrigations or debriding agents used in the treatment of a skin condition. (f) [illegible], or [illegible] preparations. (g) Medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a competent resident. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered	A 052		

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A 052	Continued From page 30 administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in section 429.256, F.S. and this rule. (b) In addition to the specifications of section 429.256(3), F.S., assistance with self-administration of medication includes, in the presence of the resident, reading the medication label aloud and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a	A 052		

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A 052	Continued From page 31 medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in section 429.256(4), F.S. 1. As used in section 429.256(4)(g), F.S., the term "competent resident" means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication. 2. As used in section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (g) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that staff followed the procedures described in section 429.256, F.S. while assisting 9 out of 15 sampled residents with self-administration of medications (Resident's # 1, #2, #4, #5, #6, #7, #8, and #10	A 052		

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A 052	Continued From page 32 and #11). The facility's staff did not read the medications names aloud to the residents when assisted them with their medications. The facility failed to adhere to to control policy and procedures when assisting with self-administration of medication. The facility's staff used the same medicine cup to dispense medications for each resident and the resident's put the medicine cup to their . Facility staff failed to wash/sanitize the medicine cup before giving it to the next resident. The facility's staff did not wash/sanitize their between residents when assisted the residents with self-administration of medications. Findings included: Review of Resident #1's record showed that there was a health assessment completed on . The assessment indicated Resident #1 who has medical history and diagnoses of type II, high , low energy, , and at times, needed assistance with self-administration of medication. Observation on at 6:48 AM showed that Staff E assisted Resident #1 with self-administration of medications. The staff took seven resident's medications containers and took the prescribed tablet out from each one. The staff placed the pills in a small clear plastic cup which Resident #1 placed over his , for dropping the medications inside his . The staff did not read the medications' names to the resident aloud. Review of Resident#1's Medication Observation Record (MOR) showed that the medications he took were -Omega	A 052		

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A 052	Continued From page 33 3- Esters, 600 mg, 1000 mg, XL 5 mg, 20 mg, .5 mg, and 1 mg. Review of Resident #2's record showed that there was a health assessment (AHCA form 1823) completed on . The resident had medical history and diagnoses of , cigarette dependence, mild and . The assessment showed that the resident needed help taking his medications and the resident needed to be reminded and monitored with medication intake. In an interview on at 7:57 AM, Staff D stated that Resident #2 received assistance with self-administration of medications. In an interview on at 7:59 AM, Staff E stated that Resident #2 received assistance with self-administration of medications. Review of progress notes for Resident #2 showed that on the facility gave the medications to the resident for 5 days to take home with him. In an interview on at 8:37 AM, Staff G stated that Resident #2 went with his family on when the facility gave him the medications. The facility did not have any information for Resident #2's family. The facility in fact was not sure if the resident went with his family or took his medications. Observation on at 7:00 AM showed that Staff E finished assisting Resident #1 with self-administration of medications, removed her gloves and put new gloves. The staff did not	A 052		

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A 052	Continued From page 34 wash her . . . . or use . . . sanitizer before starting to assist Resident #2 with self-administration of medication on . . . . . at 7:01 a.m. The staff assisted Resident #2 with self-administration of medication. Staff E placed the pills in a small clear plastic cup (same clear plastic cup used for Resident #1), which Resident #2 placed over his , for dropping the medications inside his . . . . . The staff did not read the medications' names to the resident aloud. Review of Resident#2's Medication Observation Record (MOR) showed that the medications he took were , ... 2 mg, , . . 250 mg, and . , 300 mg. Observation on at 7:09 AM showed that Staff E removed her gloves and put on new gloves after assisting Resident # 2. The staff did not wash her . . . or use . . . sanitizer before starting to assist Resident #4. The staff did not read the medications' names to the resident aloud. Medication Observation Record (MOR) showed that the medications this resident took were , 10 mg, , 500 mg, . . , 5 mg, and . . . . . , 1 mg. Observation on . . . . . at 7:17 AM showed that Staff E removed her gloves and put on new gloves after assisting Resident # 4. The staff did not wash her or use sanitizer before starting to assist Resident #6. The staff did not read the medications' names to the resident aloud. Medication Observation Record (MOR) showed that the medications this resident took were . . . . 25 mg, ... , . MES 2 mg, 1 mg, 20 mg, , 10 mg, . . . , ... 40 mg, ... , . . 1 mg, C, ... CL 10 MEQ, and , .	A 052		

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A 052	Continued From page 35 Drops - 0.5 %. Observation on at 7:28 AM showed that Staff D did not wash her or use sanitizer before starting to assist Resident #5. The staff did not read the medications' names to the resident aloud. Medication Observation Record (MOR) showed that the medications this resident took were 2 mg, 2 mg, 0.5 mg, 30 mg, and HCl 10 mg. Observation on at 7:37 AM showed that Staff E removed her gloves and put on new gloves after assisting Resident # 6. The staff did not wash her or use sanitizer before starting to assist Resident #11. The staff did not read the medications' names to the resident aloud. Medication Observation Record (MOR) showed that the medications this resident took were 1 mg, 5 mg, 1 mg, 20 mg, Sul 325 mg, and 1 mg. Review of Resident #11's record showed there was a health assessment completed on . The assessment indicated that Resident #11 needed assistance with self-administration of medications. Observation on at 7:46 AM showed that Staff E removed her gloves and put on new gloves after assisting Resident # 11. The staff did not wash her or use sanitizer before starting to assist Resident #8. The staff did not read the medications' names to the resident aloud. Medication Observation Record (MOR) showed that the medications this resident took were 2 mg,	A 052		

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A 052	Continued From page 36 300 mg, and . . , . 5 mg. Observation on . ... at 7:50 AM showed that Staff D removed her gloves when finished and put on new gloves after assisting Resident # 10. The staff did not wash her or use sanitizer before starting to assist Resident #7. The staff did not read the medications' names to the resident aloud. Review of Resident # 7's Medication Observation Record (MOR) showed that the resident took were . . . . . , . 1 mg, . . , . . DR 250 mg, . . . Sod 100 mg, . . 500 mg, ... 500 mg, ... 1 mg, . . , . . 40 mg, . . , 0.5 mg, and . . , . . 81 mg. In an interview on . . . . . at 7:01 AM, Staff E stated she was not using the same cup between Resident#1 and Resident #2. She started washing the cup between residents. The staff confirmed that she did not read aloud the medications' names to the residents. In an interview on at 7:55 AM, Staff D did not explain the reason for not reading the medications' names aloud to the residents. Class III	A 052		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing	A 054		

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A 054	Continued From page 37 pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known [illegible] the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical [illegible], the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to immediately update Medication Observation Records (MORs) each time residents received assistance with self-administration of medications for 10 out of 15 sampled residents (#1, #2, #4, #5, #6, #7, #8, #9, #10 and #11). The facility failed to ensure that the residents' MORs included the [illegible], the name of the resident's health care provider and the health care provider's telephone number and chart for recording any missed dosages or refusals to take medication as prescribed for 10	A 054		

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A 054	Continued From page 38 out of 15 sampled residents (#1, #2, #4, #5, #6, #7, #8, #9, #10 and #11). Findings included: 1. Review of MORs for Residents #1, #2, #4, #5, #6, #7, #8, #9, #10 and #11 on [redacted] at 6:56 AM showed that the staff did not initial the MORs for the evening medications for [redacted] and the morning medications for [redacted]. The schedule on the MORs for the evening medications was at 8 PM while for the morning medications was at 8 AM. In an interview on [redacted] at 6:50 AM, Staff C stated that the ten residents in the facility already took their medications. Staff C added on [redacted] at 7:25 AM that the residents took their medications around 6 AM. 2. Review of Residents #6, #10 and #11's MORs showed that the section for documenting the [redacted] was blank. Review of Residents #2, #4, #5, #8, and #9's MORs showed missing the [redacted], the name of the resident's health care provider and the health care provider's telephone number. Review of MORs for Resident #1 showed that showed missing the [redacted], the name of the resident's health care provider and the health care provider's telephone number. The MORs also showed the staff did not initial as given, leaving blank spaces for [redacted] 100 mg, from [redacted] until [redacted] on the 8 AM dose and Rosuvastatin [redacted] 10 mg any dates for [redacted]. Review of MORs for Resident #7 showed that the	A 054		

Agency for Health Care Administration

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A 054	Continued From page 39 section for documenting the [illegible] was blank. The MORs also showed that the staff did not initial any of his medications as given, leaving blank spaces from [illegible] to [illegible]. Class III	A 054		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to	A 055		

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A 055	Continued From page 40 other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise	A 055		

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	AL11966003	A. BUILDING: _____ B. WING _____	02/29/2020

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SARA HOME CARE	29100 SW 172 AVENUE HOMESTEAD, FL 33030

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A 055	Continued From page 41 prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain and dispose of medication in a safe manner. Findings included: Observation on at 7:38 AM showed Staff E assisted Resident #6 with self-administration of medication when one tablet 1 mg on the table and one tablet of C on the floor. On further observation at 8:57 AM, Staff E disposed of unused medications inside the garbage can in the kitchen. The garbage can was accessible to all residents. In an interview on at 8:57 AM, Staff E stated she disposed the medication not used by placing them with the gloves and into the garbage can in the kitchen.	A 055		

Agency for Health Care Administration

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A 055	Continued From page 42 Class III	A 055		
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	A 078		

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A 078	Continued From page 43 certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility . . . . . to provide services to residents must ensure that individuals providing services are qualified to 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 observation, record review and interview, the facility failed to ensure that staff had a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . . . . . and a negative examination within 30 days after beginning employment for one out of nine sampled staff (Staff F). Findings included:	A 078		

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A 078	Continued From page 44 Observation on at 6:12 AM showed that Staff F was at the facility taking care of 10 residents. In an interview on at 6:12 AM, Staff F stated that she was by herself at the facility with 10 residents. Review of Staff F's personnel record showed that there was a job application with date of completion on . There was no evidence of a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable and a negative examination. Review of policy reports related to the facility's address showed that Staff F worked at the facility on when called for Resident #1 and on when called for Resident #13. In an interview on at 7:49 AM, Staff G stated that she just had the job application and the background screening result for Staff F. Class III	A 078		
A 079 SS=J	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 212	A 079		

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A 079	Continued From page 45	A 079		

16-25 253
26-35 294
36-45 335
46-55 375
56-65 416
66-75 457
76-85 498
86-95 539

For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week.
2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours.
3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility.
4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night.
5. A staff member who has completed courses in First Aid and , , , ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times.
a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement.
b. A nurse is considered as having met the

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A 079	Continued From page 46 course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and [illegible] 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least [illegible] must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007,	A 079		

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A 079	Continued From page 47 F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased	A 079		

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A 079	Continued From page 48 staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs. The facility failed to have a staff member with a current and valid First Aid and , , ( ) course in the facility at all times. The facility failed to ensure to maintain the minimum staff hours per week of 212 hours. The facility failed to maintain a written work schedule that reflects its 24-hour staffing pattern. Findings included: 1. Observation on at 6:40 AM showed that Resident #9 opened the front door of the facility. Staff C walked from the kitchen to the living room. Staff C was at the facility taking care of 10 residents (#1, #2, #4, #5, #6, #7, #8, #9, #10 and #11). Residents #1 and #7 sat in the	A 079		

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A 079	Continued From page 49 dining room. Resident #2 ambulated in the facility, Resident #4 walked out from the bedrooms area to the living room. Resident #6 sat on an armchair while Resident #9 sat the couch in the living room. Resident #10 sat on the porch. Residents #5, #8, and #11 rested on bed in their bedrooms. In an interview on at 6:50 AM, Staff C stated that she worked every day from 6 PM to 7 AM. Observation on at 7:16 AM showed that Staff C removed an air mattress from the living room. In an interview on at 7:25 AM, Staff C stated that she slept on the air mattress that was in the living room. She stayed up watching TV until late, around 11 PM. She woke up during the night if there was any noise or if the residents needed her. Review of facility's record showed that the facility did not have any staff in the facility from 6 PM to the following day at 8 AM during Saturdays and Sundays while the residents were in the facility. Review of progress notes for Resident #1 showed that the resident from the facility during the night shift on (Saturday). Review of the photo provided by Neighbor #1 showed that Resident #1 was on her property. Review of copies of letters delivered by registered mail to the facility and emails sent to the facility's owner. The documents showed that neighbors contacted the facility's owner and made him aware of the situations of residents, copies of	A 079		

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A 079	Continued From page 50 police reports about, and photographs of residents on her property for at least the last six months. Review of the photo provided by Neighbor #1 showed that Resident #1 was on her property. Review of copies of letters delivered by registered mail to the facility and emails sent to the facility's owner. The documents showed that neighbors contacted the facility's owner and made him aware of the situations of residents, copies of police reports about, and photographs of residents on her property for at least the last six months. In an interview on at 2:52 PM, Neighbor #1 stated to that Resident #1 was on her property looking through the windows at 2:33 AM on and looking under the flowerpots for a key to enter. Neighbor #1 explained that the situation happened for at least six months, with different residents. In an interview on at 3:27 PM, Neighbor #2 stated that traffic ran between 70 and 80 miles per hour on that dark street where the facility was at. The neighbor expressed concerns about the residents ambulating on dark streets during night hours because they were at risk to be hit by local traffic. Review of adverse incident reports on showed that the facility filed six adverse incidents reports for Resident #1 on , . The resident missed from on , , , , , and . On the resident went into one of the facility's neighbor. On the resident had dirty clothes and on the arms when he	A 079		

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A 079	Continued From page 51 returned to the facility. Resident #1 explained to Staff B on that he while was out of the facility. On a local hospital contacted the facility and notified them that Resident #1 was in the emergency room after being found incoherent on a busy street intercession by the police. In an interview on at 8:09 AM, Staff B stated that Resident #1 knocked in one of the neighbor's house in the middle of the night. The resident went out to buy cigarettes. The facility did not lock the doors. The facility did not know at what time he left on . On a further at 9:46 AM, Staff B, the owner, added that the facility did not have a problem with supervision and that residents were free to go in and out of the facility. In an interview on at 7:11 AM, Staff D stated that Resident #1 from the facility during the weekend and the facility called the law enforcement. According to the staff, Resident #1 from the facility on multiple occasions and during different times of the day and night. The staff on duty called the law enforcement when the resident missed from the facility and the police brought Resident #1 "like every day". The staff did not know where Resident #1 was when he from the facility. In an interview on at 8:29 AM, Staff G stated that Resident #1 smelled when the police brought him on . Review of police reports in reference to the facility's address showed that the facility contacted the police at least in two different occasions during , because Resident #1 missed from the facility. One of the calls was on at 9:16 PM and the staff on	A 079		

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A 079	Continued From page 52 duty advised the police that "for the past few days has been running away from the ALF and has almost placed himself in front of vehicles on purpose." The police report further stated "The patient has entered stranger vehicles and has been transported to other locations." The other call was on [redacted] at 1 PM and the report showed that Staff B found Resident #1 around 2 miles away from the facility. Review of Resident #1's record showed that there was a health assessment completed on [redacted]. The assessment indicated Resident #1 who has medical history and diagnoses of [redacted] type II, high [redacted], low energy, [redacted] and [redacted] at times. Review of police report showed that the facility contacted the police on [redacted] at 7:36 AM because Resident #13 missed from the facility since [redacted]. The resident walked out of the facility on [redacted] at approximately 7:15 PM and never returned. The facility admitted the resident on [redacted] around noon after he had been hospitalized for 66 days at a crisis local hospital. The staff advised the police that the resident suffered from "unknown mental condition" and that the court system placed the resident in the facility. The police investigator found out a month later that the resident violated the terms placed by court when he left the facility. The court issued an alias capias warrant on [redacted]. Review of Neighbor #1's statement revealed that on the afternoon of [redacted], one of the residents from the facility was on her property. In an interview on [redacted] at 9:43 AM, Staff B stated having a resident who went to the facility's	A 079		

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A 079	Continued From page 53 neighbor house and knocked at the door on 2019. The staff informed that the resident was a new admission to the facility who went out to buy cigarettes and got lost. Staff B stated that he did not remember the name of the resident or the date of the incident. The staff added that the incident was around . . . . . . Review of police report showed that the facility contacted the police on at 5 PM because Resident #15 missed from the facility. According to the police report the resident left the facility around 2 PM and did not return. The staff on duty reported to the police officer that Resident #15 left the facility every day but for short periods of time and that the resident suffered from . . . . . . Review of the facility's record there was no documentation of when Resident #15 returned or left again. Review of the admission and discharged log showed that Resident #15's discharge date was on . . . . . . Review of Neighbor #1's evidence showed that she wrote a letter to Staff B and to the facility on . . . . . and sent it certificate on . . . . . . On the letter Neighbor #1 informed the facility that residents from the facility trespassed her property during in multiple occasions on during the previous months. The neighbor stated informing the facility related about the situations and she did not see the facility or the facility's owner took any actions about it. Neighbor #1 expressed being concern for her personal safety. The last incident was on when a resident from the facility was in her driveway, and fully exposing his . Neighbor #1 also stated	A 079		

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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 079	Continued From page 54 texting Staff B who replied that the neighbor did not have evidence. Review of Neighbor #2's email sent to Staff B on [redacted] showed the neighbor informing Staff B about an incident she witnessed with one of the facility's resident at Neighbor #1's property. Neighbor #2 stated that the facility was located in a very small neighborhood where they knew each other. The neighbor indicated that on around 5:20 PM she saw a resident from the facility standing in Neighbor #1's driveway, [redacted] on the lawn completely exposing his [redacted]. Observation on [redacted] at 6:50 AM and at 8:31 AM showed Resident #6 sat in the living room. The resident pulled up his t-shirt, covered his while he made loud noises and screamed repeatedly. Resident # 9 redirected Resident #6 on both occasions when Resident #9 said that he was going to call the police if Resident #6 did not stop making those noise. Observation on [redacted] at 6:12 AM showed Resident #6 sat in the living room while he pulled up his t-shirt, covered his [redacted] while he made loud noises and screamed repeatedly. Resident # 9 redirected Resident #6 to stop making those noise. Observation on [redacted] at 7:31 AM showed Resident #6 sat in the living room while he pulled up his t-shirt, covered his [redacted] while he made loud noises and screamed repeatedly. Resident # 9 yelled to Resident #6 "Be quiet!". Review of Resident #6's record showed that that there were some discharge papers from the hospital. The resident was at a local hospital from	A 079		

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A 079	Continued From page 55 [redacted] to [redacted] and from [redacted] to [redacted] where received treatment for [redacted]. The hospital record showed that [redacted] was a severe loss of contact with reality. People who had [redacted] were not able to think clearly and their emotions and responses did not match with what actually happened making them to be very upset and have chaotic behaviors. Review of progress notes for Resident #6 showed that on [redacted] the facility sent the resident to the hospital because he was very aggressive, screaming and did not sleep. The facility sent the resident to the hospital on [redacted] because he was very aggressive. Review of progress notes for Resident #6 completed on [redacted] indicated that the resident was aggressive with the staff. The resident did not allow that staff touched him, did not want to bath or change clothes and kept screaming the whole day since them. Review of police reports showed that the facility contacted the police on [redacted] at 2:36 PM because Resident #12 was violent and made threats to staff. The resident went into other residents and staff members' faces, threatening them. The residents and staff members locked themselves in the resident's rooms or the office because of Resident #12's behavior. The staff advised the police "Resident #12 does take medications for [redacted] but the staff was not sure if he took them today"'. The resident was hospitalized under [redacted]. In an interview on [redacted] at 9:48 AM, Staff B stated that the facility did not implement any new measure for ensuring that the residents had the required supervision because the facility did not	A 079		

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A 079	Continued From page 56 have a problem giving the right supervision to the residents. The staff added that the residents were free to go in and out of the facility. 2. Observation on at 6:12 AM showed that Resident #2 opened the front door of the facility. Staff F walked from the porch to the living room. Staff F was at the facility taking care of 10 residents (#1, #2, #4, #5, #6, #7, #8, #9, #10 and #11). Review of Staff F's record showed that her job application had the date of . There was no evidence that the staff held a First Aid and ( ) training. In an interview on at 6:12 AM, Staff F stated that she did not work at the facility, she just did laundry and housekeeping. The staff did not provide care to the residents. Staff E left but would be soon. Staff E went to her house to wake up a family member and to give a medication. Staff F was by herself at the facility with 10 residents. In an interview on at 7:41 AM, Resident #11 stated that Staff C or F worked at the facility during the night. 3. Review of facility's record on at 7:47 AM showed that it included Staff A, B. C. D, E and G. Staff C worked Monday thru Friday from 6 PM to 7 PM for a total of 65 hours per week. Staff E worked Monday thru Friday from 7 AM to 5 PM and Saturday from 8 AM to 6 PM for a total of 60 hours per week. Staff D worked Monday thru Friday and Sunday from 8 AM to 6 PM for a total of 60 hours per week but teh staff actually worked 12 hours. The minimum staff hours per week was of 137 hours.	A 079		

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A 079	Continued From page 57 In an interview on at 9:41 AM, Staff E stated that Staff A and B would work on the night of . In an interview on at 9:46 AM, Staff B stated that Staff A, B, and C worked on nights during the weekends. The facility did not have document the hours worked on nights during the weekend but Staff B had evidence of the worked hours that would provide at a later time. On a further interview at 9:48 AM, Staff B added that Staff G was his assistant. Staff G worked doing papers work and checking the operation of the business but she did not provide any care or services to the residents. Staff D worked cooking 80% of the time and the rest of the time she provided care and services to the residents. Staff B also stated that neither him or Staff A provided care or services to the residents. Staff B at 9:53 AM expressed that the staffing schedule was flexible. The facility would not hire extra staffing when the number of residents could decrease at any point. On , the facility did not provide the evidence of the worked hours that Staff B on at 9:46 AM stated would provide later. 4. Observation on at 5:28 AM showed that there was no written work schedule available that reflected the facility's 24-hour staffing pattern. In an interview on at 5:33 AM, Staff E stated that she talked to Staff B by telephone. Staff B informed her that he was working on the staff schedule and he would be later at the facility. Class I	A 079		

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A 081	Continued From page 58	A 081		
A 081 SS=D	59A-36.011( ) FAC Training - Staff In-Service (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , may be used to meet this requirement.	A 081		

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

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A 081	Continued From page 60 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 observation, interview and record review, the facility failed to ensure that staff had at least 2 hours preservice orientation for one out of nine sampled staff (Staff F). The facility failed to ensure that staff received the required training within 30 days of employment for one out of nine sampled staff (Staff F). Findings included: Observation on at 6:12 AM showed that Resident #2 opened the front door of the facility. Staff F walked from the porch to the living room. Staff F was at the facility taking care of 10 residents. In an interview on at 6:12 AM, Staff F stated that she did not work at the facility, she just did laundry and housekeeping. Staff F added that Staff E left but she would be soon. Staff F was by herself at the facility with 10 residents. Review of Staff F's personnel record showed that there was a job application with date of completion on . Review of policy reports related to the facility's address showed that facility called the police for a missing person on . Staff F was on duty when the police officer arrived. Review of policy reports related to the facility's address showed that facility called the police for a missing person on . Staff F was on duty	A 081		

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A 081	Continued From page 61 when the police officer arrived. She informed the officer that Resident #13 left the facility on around 7 hours after the facility admitted him. Review of Staff F's personnel record showed that there was no evidence the staff completed the at least 2 hours preservice orientation. There were no evidence of completion for control, reporting adverse incidents, facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation, resident rights in an assisted living facility, recognizing and reporting resident , neglect, and , resident behavior and needs, providing assistance with the activities of daily living, the facility's resident elopement response policies and procedures. In an interview on at 7:49 AM, Staff G stated that she just had the job application and the background screening result for Staff F. Class III	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	A 082		

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A 082	Continued From page 62 this rule. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that staff completed (/) training with 30 days of employment for one out of nine staff sampled (Staff F). Findings included: Observation on at 6:12 AM showed that Staff F was at the facility taking care of 10 residents. In an interview on at 6:12 AM, Staff F stated that she was by herself at the facility with 10 residents. Review of Staff F's personnel record showed that there was a job application with date of completion on . There was no evidence of completion the / training. Review of policy reports related to the facility's address showed that Staff F worked at the facility on when called for Resident #1 and on when called for Resident #13. In an interview on at 7:49 AM, Staff G stated that she just had the job application and the background screening result for Staff F. Class III	A 082		
A 083 SS=D	59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND	A 083		

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A 083	Continued From page 63 . . . . . (.). A staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current . certification that requires the student to demonstrate, in person, that he or she is able to perform . and which is issued by an instructor or training provider that is approved to provide . training by the American Red Cross, the American . Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that staff completed the First Aid and . . . , , ( ) training for one out of nine staff sampled (Staff F). Findings included: Observation on . . . . . at 6:12 AM showed that Staff F was at the facility taking care of 10 residents. In an interview on . . . . . at 6:12 AM, Staff F stated that she was by herself at the facility with 10 residents.	A 083		

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A 083	Continued From page 64 Review of Staff F's personnel record showed that there was a job application with date of completion on . . . . . There was no evidence of completion the First Aid and training. In an interview on at 7:49 AM, Staff G stated that she just had the job application and the background screening result for Staff F. Class III	A 083		
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 observation, interview, and record review, the facility failed to ensure that staff completed the ( ) training with 30 days of employment for one out of nine staff sampled (Staff F). Findings included:	A 090		

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A 090	Continued From page 65 Observation on . . . . . at 6:12 AM showed that Staff F was at the facility taking care of 10 residents. In an interview on . . . . . at 6:12 AM, Staff F stated that she was by herself at the facility with 10 residents. Review of Staff F's personnel record showed that there was a job application with date of completion on . . . . . There was no evidence of completion the training. Review of policy reports related to the facility's address showed that Staff F worked at the facility on when called for Resident #1 and on . . . . . when called for Resident #13. In an interview on . . . . . at 7:49 AM, Staff G stated that she just had the job application and the background screening result for Staff F. Class III	A 090		
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	A 152		

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A 152	Continued From page 66 supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide a clean and safe living environment free of hazards. Findings included: Observation on at 6:45 AM and on at 6:17 AM during a facility tour showed # 's light did not work. In an interview on at 6:45 AM, Staff C stated that Resident #9 occupied # .	A 152		

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A 152	Continued From page 67 In an interview on at 6:17 AM, Staff D stated that Resident #9 occupied # . Observation on during a facility tour completed between 6:14 AM and 6:38 AM showed that there were stains on the furniture. The rooms contained a strong odor resembling . Class III	A 152		
A 160 SS=D	59A-36.015(1) FAC Records - Facility The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge	A 160		

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A 160	Continued From page 68 requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in rule 59A-36.007, F.A.C. (j) All food service records required in rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate.	A 160		

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	AL11966003	A. BUILDING: _____ B. WING _____	02/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SARA HOME CARE	29100 SW 172 AVENUE HOMESTEAD, FL 33030

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A 160	Continued From page 69 (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to section 429.41, F.S., and rule chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to section 381.031, F.S., and chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have an updated admission and discharge log that identified the facility or home address to which the resident was discharged. Findings included: Review of the admission and discharge log showed that eight residents were discharged from to . The facility did not identify the place of discharge for six out of eight discharged residents. In an interview completed on at 9:56 AM, Staff G stated that she did not know where those residents were discharged to. Staff G	A 160		

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A 160	Continued From page 70 further stated many of those residents finished the program that placed them here and left with the case managers. Class III	A 160		
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 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	A 161		

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A 161	Continued From page 71 429.174, 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 [redacted] 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 observation, interview and record review, the facility failed to ensure that staff had a completed job application and required training for one out of nine sampled staff (Staff F). The facility failed to have a personnel record for one out of nine sampled staff (Staff I). Findings included: 1. Observation on at 6:12 AM showed that Resident #2 opened the front door of the facility. Staff F walked from the porch to the living room. Staff F was the only staff at the facility taking care of 10 residents. In an interview on at 6:12 AM, Staff F	A 161		

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A 161	Continued From page 72 stated that she did not work at the facility. The staff said that she just did laundry and housekeeping and she did not provide care to the residents. Staff F stated that Staff E left the facility, but she would be . . . soon as Staff E went to her house to wake up a family member and to give a medication. Staff F was by herself at the facility with 10 residents. Review of Staff F's personnel record showed that there was a job application with date of completion on . Review of police reports related to the facility's address showed that the facility called the police for a missing person on . Staff F was on duty when the police officer arrived. Review of police reports related to the facility's address showed that the facility called the police for a missing person on . . . . . Staff F was on duty when the police officer arrived. She informed the officer that Resident #13 left the facility on around 7 hours after the facility admitted him. 2. Review of police reports related to the facility's address showed that the facility called the police for a missing person on . . . . . Staff I was on duty when the police officer arrived. Staff I advised the police officer that Resident #15 who suffered from , took his medications and left the facility. Class III	A 161		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records	A 162		

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A 162	Continued From page 73 must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. [illegible], 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance [illegible], 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, [illegible], or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C. (f) A [illegible] record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their [illegible] recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed	A 162		

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A 162	Continued From page 74 consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No =Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care	A 162		

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A 162	Continued From page 75 plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility	A 162		

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A 162	Continued From page 76 failed to have a completed health assessment form (AHCA form 1823) for one out of fifteen sampled residents. (#9). The facility also failed to have a completed demographic sheet for eleven out of fifteen sampled residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, and #11). Findings included: Review of Resident #1's record showed that his admission date to the facility was on . . . . The demographic sheet missed the information of the health care provider and had the wrong information for the resident's case manager. In an interview on at 8 AM, Staff G stated that Resident #1's case manager changed approximately two or three weeks ago. Review of Resident #2's record showed that his admission date to the facility was on . . . . The demographic sheet missed the social security number, the information of an individual designated by the resident for notification in case of an emergency, and the information of the health care provider. The demographic sheet had the wrong information for the resident's case manager. The resident's record did not have any information for the local program that the resident attended. In an interview on at 8:37 AM, Staff G stated that Resident #2's case manager changed since . The resident had family, but the facility did not have any contact information. Review of Resident #3's record showed that his admission date to the facility was on . The demographic sheet missed the information of the health care provider.	A 162		

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A 162	Continued From page 77 Review of Resident #6's record showed that his admission date to the facility was on . . . . . . The demographic sheet missed the information of the health care provider. Review of Resident #7's record showed that his admission date to the facility was on . The demographic sheet missed the information of the health care provider. Review of Resident #10's record showed that his admission date to the facility was on . . . . . . The demographic sheet missed the information of an individual designated by the resident for notification in case of an emergency, and the information of the health care provider. Review of Resident #11's record showed that her admission date to the facility was on . The demographic sheet missed the information of the health care provider. In an interview on at 9:03 AM, Staff G stated that Residents #3, #6, #7, #10 and #11 had the same health care provider and psychiatrist. Review of Resident #8's record showed that his admission date to the facility was on . . . . . . The demographic sheet missed the information of the health care provider. In an interview on . . . . . at 9:17 AM, Staff G stated that Resident #8 did not have a doctor. The resident went to a local clinic. One of the doctors at the local clinic checked on him and gave him his medications. Review of Resident #9's record showed that his admission date to the facility was on .	A 162		

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A 162	Continued From page 78 The demographic sheet missed the social security number, the information of an individual designated by the resident for notification in case of an emergency, and the information of the health care provider. There was no evidence of a completed resident health assessment form (AHCA form 1823). In an interview on [redacted] at 9:23 AM, Staff G stated that Resident #9 went to a local clinic. One of the doctors at the local clinic checked on him. The clinic never gave a completed health assessment form (AHCA form 1823) to the facility. Review of Resident #4's record showed that his admission date to the facility was on [redacted]. The demographic sheet missed the information of the health care provider. In an interview on [redacted] at 9:30 AM, Staff G stated that Resident #4 went to a local clinic. One of the doctors at the local clinic checked on him. Review of Resident #5's record showed that his admission date to the facility was on [redacted]. The demographic sheet missed the information of the health care provider. In an interview on [redacted] at 9:35 AM, Staff G stated that the facility did not know who the doctor for Resident #5 was. The resident's mother took him to the doctor. In an interview on [redacted] at 10 AM, Staff B stated that they were unaware the residents required a completed demographic sheet. Class III	A 162		

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A 165	Continued From page 79	A 165		
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) 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	A 165		

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A 165	Continued From page 80 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 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	A 165		

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A 165	Continued From page 81 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 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 record review and interview, the facility failed to submit an adverse incident within one business day and within 15 days after the incident to The Agency for Healthcare Administration (AHCA) for six out of fifteen sampled residents (#1, #13, #15, #12, #5, and #14). Findings included: Review of AHCA Incident Reporting System on at 6 AM showed that the facility had just	A 165		

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	AL11966003	A. BUILDING: _____ B. WING _____	02/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SARA HOME CARE	29100 SW 172 AVENUE HOMESTEAD, FL 33030

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A 165	Continued From page 82 one adverse incident report on file. The facility filed that adverse incident report on in reference to an incident with Resident #3 on . Review of police reports showed that the facility called in reference to missing persons on four different occasions (, , and). Two of the calls were in reference to Resident #1 and the rests of the calls were in reference to Residents #13 and #15. Review of police record showed that Resident #1 eloped from the facility on . Staff B found the resident two miles away from the facility. Review of police record showed that Resident #1 was eloped from the facility on at 9:08 PM. Staff F advised the police officer that Resident #1 suffered from , and , . The staff also shared with the police officer that the resident ran away from the facility for the past few days almost placing himself in front of vehicles on purpose. The staff added that Resident #1 entered stranger's vehicles and transported to other locations. The resident was backer acted. Review of police record showed that the facility called the police on at 7:36 AM because Resident #13 eloped from the facility since around 7:15 PM. Staff F advised the police officer that the facility admitted Resident #13 on around noon after the resident had a hospitalization of 66 days. The staff also shared with the police officer that the resident suffered from an unknown mental condition. The police investigation finished on when the investigator found out the resident was under court order condition and the court ordered a	A 165		

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A 165	Continued From page 83 warrant on . . . . . . Review of police record showed that the facility called the police on at 5 PM because Resident #15 eloped from the facility. Staff F advised the police officer that the resident suffered from . . . , . . and left the facility around 2 PM. Review of police reports showed that the facility called for backer act residents on four different occasions (, , and . . . . .). Two of the calls were in reference to Resident #12 and the rests of the calls were in reference to Residents #5 and #14. Review of police record showed that the facility called the police on at 5:16 PM in reference to a battery. Staff E advised the police officer that Resident #12 was in crisis. The police officer found Resident #12 yelling and screaming outside the facility in the rear. The resident screamed that he was shot in the . . . of the and wanted to go to see his father. The police officer backer acted Resident #12. Review of police record showed that the facility called the police on at 2:36 PM in reference to a violent resident making threats to staff. Staff G stated to the police officer that Resident #12 behaved violently to her and other staff members. The staff advised that Resident #12 came in and out of his room and got into both residents and staff members' faces threatening to hit them. Staff G further stated to the police that Resident #12's behavior caused the residents and staff members to lock themselves into the resident's rooms and offices. The police officer backer acted Resident #12.	A 165		

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A 165	Continued From page 84 Review of police record showed that Resident #5 called the police on at 11:49 AM because he wanted to be backer acted. The resident reported to the police officer that he suffered from , , , and , . Resident #5 informed the police that he had thoughts of overdosing and killing himself with prescribed medication. The police officer backer acted Resident #5. Review of police record showed that the facility called the police on at 12:53 PM in reference to a medical episode. The facility advised the police officer that Resident #14 was a resident who was supposed to receive , and refused. The police officer found Resident #14 very agitated. The resident stated to the police that he wanted the police to give him the gun so he "would blow his out" because he did not want to live any more. The police officer backer acted Resident #14. In an interview on at 8:17 AM, Staff B stated that the facility completed the adverse incident report for Resident #1 the day before. The staff added that the completed incident was in reference to the incident at the beginning of with Resident #1. In an interview on at 4 PM the Administrator stated that she completed the adverse incident reports for the facility. Class III	A 165		

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CZ814 SS=C	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12(2) Care Provider Background Screening Clearinghouse.- (b) Until such time as the [illegible] 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 [illegible] 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; [illegible]; 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: Base on observation, record review and interview, the facility failed to maintain the employment status of all employees within the clearinghouse by reporting initial employment status within 10 business days for one out nine sampled staff (Staff F). Findings included:	CZ814		

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CZ814	Continued From page 1 Observation on at 6:12 AM showed that Resident #2 opened the front door of the facility. Staff F walked from the porch to the living room. Staff F was at the facility taking care of 10 residents. In an interview on at 6:12 AM, Staff F stated that she did not work at the facility, she just did laundry and housekeeping. The other staff walked out of the facility and would be . . . . Staff F was by herself at the facility with 10 residents. Review of background clearinghouse showed that Staff F had start date on and the end date on . . . . . Review of Staff F's record showed that her job application had the date of . . Unclassified	CZ814		
CZ815 SS=C	408.809; 435.02(2); 435.06 FS Background Screening; Prohibited Offenses 408.809 Background screening; prohibited offenses.- (1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are considered employees for the purposes of conducting screening under chapter 435: (a) The licensee, if an individual. (b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider. (c) The financial officer or similarly titled individual who is responsible for the financial operation of	CZ815		

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CZ815	Continued From page 2 the licensee or provider. (d) Any person who is a controlling interest. (e) Any person, as required by authorizing statutes, seeking employment with a licensee or provider who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, ␣ with a licensee or provider whose responsibilities require him or her to provide personal care or personal services directly to clients, or ␣ with a licensee or provider to work 20 hours a week or more who will have access to client funds, personal property, or living areas. Evidence of contractor screening may be retained by the contractor's employer or the licensee. (3) All ␣ , must be provided in electronic format. Screening results shall be reviewed by the agency with respect to the offenses specified in s. 435.04 and this section, and the qualifying or disqualifying status of the person named in the request shall be maintained in a database. The qualifying or disqualifying status of the person named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee's behalf. (4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an ␣ awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of	CZ815		

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CZ815	Continued From page 3 another jurisdiction: (a) Any authorizing statutes, if the offense was a felony. (b) This chapter, if the offense was a felony. (c) Section 409.920, relating to Medicaid provider fraud. (d) Section 409.9201, relating to Medicaid fraud. (e) Section 741.28, relating to domestic violence. (f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection. (g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems. (h) Section 817.234, relating to false and fraudulent insurance claims. (i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony. (j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider. (k) Section 817.505, relating to patient brokering. (l) Section 817.568, relating to criminal use of personal identification information. (m) Section 817.60, relating to obtaining a credit card through fraudulent means. (n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony. (o) Section 831.01, relating to forgery. (p) Section 831.02, relating to uttering forged instruments. (q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes. (r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes. (s) Section 831.30, relating to fraud in obtaining medicinal drugs. (t) Section 831.31, relating to the sale,	CZ815		

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CZ815	Continued From page 4 manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony. (u) Section 895.03, relating to racketeering and collection of unlawful debts. (v) Section 896.101, relating to the Florida Money Laundering Act. If, upon rescreening, a person who is currently employed or with a licensee as of , and was screened and qualified under ss. 435.03 and 435.04, has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency no later than 30 days after receipt of the rescreening results by the person. (5) A person who serves as a controlling interest of, is employed by, or contracts with a licensee on , who has been screened and qualified according to standards specified in s. 435.03 or s. 435.04 must be rescreened by , in compliance with the following schedule. If, upon rescreening, such person has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a	CZ815		

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CZ815	Continued From page 5 decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency within 30 days after receipt of the rescreening results by the person. The rescreening schedule shall be: (a) Individuals for whom the last screening was conducted on or before , must be rescreened by . (b) Individuals for whom the last screening conducted was between , and , must be rescreened by . (c) Individuals for whom the last screening conducted was between , through , must be rescreened by . (6) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening. (7)(a) As provided in chapter 435, the agency may grant an exemption from disqualification to a person who is subject to this section and who: 1. Does not have an active professional license or certification from the Department of Health; or 2. Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification. (b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may grant an exemption from disqualification to a person who is subject to this section and who has	CZ815		

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CZ815	Continued From page 6 received a professional license or certification from the Department of Health or a regulatory board within that department and that person is providing a service within the scope of his or her licensed or certified practice. (8) The agency and the Department of Health may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, chapter 435, and authorizing statutes requiring background screening and to implement and adopt criteria relating to retaining [illegible] pursuant to s. 943.05(2). (9) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this section, terminates the person against whom the report was issued, whether or not that person has filed for an exemption with the Department of Health or the agency. 435.06 Exclusion from employment.- (1) If an employer or agency has reasonable cause to believe that grounds exist for the denial or termination of employment of any employee as a result of background screening, it shall notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity. (2)(a) An employer may not hire, select, or otherwise allow an employee to have contact with any [illegible] person that would place the employee in a role that requires background screening until the screening process is	CZ815		

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CZ815	Continued From page 7 completed and demonstrates the absence of any grounds for the denial or termination of employment. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select, or otherwise allow the employee to have contact with any person that would place the employee in a role that requires background screening unless the employee is granted an exemption for the disqualification by the agency as provided under s. 435.07. (b) If an employer becomes aware that an employee has been for a disqualifying offense, the employer must remove the employee from contact with any person that places the employee in a role that requires background screening until the is resolved in a way that the employer determines that the employee is still eligible for employment under this chapter. (c) The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of this chapter or place the employee in a position for which background screening is not required unless the employee is granted an exemption from disqualification pursuant to s. 435.07. (d) An employer may hire an employee to a position that requires background screening before the employee completes the screening process for training and orientation purposes. However, the employee may not have direct contact with persons until the screening process is completed and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment. (3) Any employee who refuses to cooperate in such screening or refuses to timely submit the	CZ815		

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CZ815	Continued From page 8 information necessary to complete the screening, including , if required, must be disqualified for employment in such position or, if employed, must be dismissed. (4) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages against, an employer that, upon notice of a conviction or for a disqualifying offense listed under this chapter, terminates the person against whom the report was issued or who was , regardless of whether or not that person has filed for an exemption pursuant to this chapter. 435.02 Definitions.-For the purposes of this chapter, the term: (2) "Employee" means any person required by law to be screened pursuant to this chapter, including, but not limited to, persons who are contractors, licensees, or volunteers. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that staff having access to living residents' personal property and living areas have an eligible level 2 background screening for one out of eight sampled staff (Staff H). Findings included: In an interview on at 6:35 AM, Staff E stated that the Staff H lived in the building on the of the facility. Staff H was like a handyman. He made some works at the facility fixing things inside. Review of Staff H's record showed that the facility did not have any record for him. There was no evidence of background screening level 2	CZ815		

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CZ815	Continued From page 9 completed for Staff H. In an interview on at 10 AM, Staff B stated that the facility did not have the background screening for Staff H. Unclassified	CZ815		
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 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	CZ816		

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	AL11966003	A. BUILDING: _____ B. WING _____	02/29/2020

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SARA HOME CARE	29100 SW 172 AVENUE HOMESTEAD, FL 33030

(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
CZ816	Continued From page 10 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 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	CZ816		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CZ816	Continued From page 11 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_Service s/Background_Screening/Regulations_Forms.sht ml. This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if for any disqualifying offense. (e) An administrator or chief financial officer must be screened and qualified prior to , , to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's 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	CZ816		

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CZ816	Continued From page 12 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 observation, record review and interview, the facility failed to ensure that a staff with a break in service from a position for more than 90 days had an updated background level 2 and attestation of compliance with background screening requirement for one out eight sampled staff (Staff F). Findings included: Observation on [redacted] at 6:12 AM showed that Resident #2 opened the front door of the facility. Staff F walked from the [redacted] porch to the living room. Staff F was at the facility taking care of 10 residents. In an interview on [redacted] at 6:12 AM, Staff F stated that she did not work at the facility, she just did laundry and housekeeping. The other staff walked out of the facility and would be [redacted]. Staff F was by herself at the facility with 10 residents. Review of Staff F's record showed that her job application had the date of [redacted]. The	CZ816		

Agency for Health Care Administration

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CZ816	Continued From page 13 background screening result showed eligible on . There was no documentation for attestation of compliance with background screening requirement. Unclassified	CZ816		