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 _____	R 05/11/2020

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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{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 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	{CZ816}		

AHCA Form 3020-0001

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

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{CZ816}	Continued From page 1 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 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	{CZ816}		

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{CZ816}	Continued From page 2 reference, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-09106, and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Regulations_Forms.shtml. This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if . . . . . for any disqualifying offense. (e) An administrator or chief financial officer must be screened and qualified prior to , , . to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the . . . . report and court disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with section 435.06(3), F.S. (c) The eligibility results of employee screening and the signed Attestation referenced in	{CZ816}		

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{CZ816}	Continued From page 3 subsection 59A-35.090(2), F.A.C., must be in the employee's personnel file, maintained by the provider. This Statute or Rule is not met as evidenced by: Based on record review and 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 screening for one out of 10 sampled staff (Staff F). Findings included: Review of the facility's staff schedule for week of to showed that Staff F worked Monday, Wednesday, and Thursday from 5 PM to 8 AM, Saturday from 8 AM to 6 PM and Sunday from 7 AM to 5 PM. Review of background screening database showed that the facility hired Staff F on and the ended date was . The background screening database also showed that there was no employment history for Staff F until when the facility hired her again. The background screening database showed that Staff F had the last screening completed on and it showed the eligible result on . During an interview with the administrator on at 12:34 PM, the administrator stated that Staff F started working at the facility when she completed her background screening. The administrator added that Staff F stopped working on the facility for sometime and then returned. The administrator stated that not knowing that Staff F needed an updated background screening level.	{CZ816}		

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{CZ816}	Continued From page 4 Uncorrected Unclassified	{CZ816}		
CZ824 SS=C	408.811 FS; 59A-35.120 FAC Right of Inspection; Inspection Reports 408.811 Right of inspection; copies; inspection reports; plan for correction of deficiencies.- (1) An authorized officer or employee of the agency may make or cause to be made any inspection or investigation deemed necessary by the agency to determine the state of compliance with this part, authorizing statutes, and applicable rules. The right of inspection extends to any business that the agency has reason to believe is being operated as a provider without a license, but inspection of any business suspected of being operated without the appropriate license may not be made without the permission of the owner or person in charge unless a warrant is first obtained from a circuit court. Any application for a license issued under this part, authorizing statutes, or applicable rules constitutes permission for an appropriate inspection to verify the information submitted on or in connection with the application. (a) All inspections shall be unannounced, except as specified in s. 408.806. (b) Inspections for relicensure shall be conducted biennially unless otherwise specified by authorizing statutes or applicable rules. (2) Inspections conducted in conjunction with certification, comparable licensure requirements, or a recognized or approved accreditation organization may be accepted in lieu of a complete licensure inspection. However, a licensure inspection may also be conducted to review any licensure requirements that are not	CZ824		

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CZ824	Continued From page 5 also requirements for certification. (3) The agency shall have access to and the licensee shall provide, or if requested send, copies of all provider records required during an inspection or other review at no cost to the agency, including records requested during an offsite review. (4) A deficiency must be corrected within 30 calendar days after the provider is notified of inspection results unless an alternative timeframe is required or approved by the agency. (5) The agency may require an applicant or licensee to submit a plan of correction for deficiencies. If required, the plan of correction must be filed with the agency within 10 calendar days after notification unless an alternative timeframe is required. (6)(a) Each licensee shall maintain as public information, available upon request, records of all inspection reports pertaining to that provider that have been filed by the agency unless those reports are exempt from or contain information that is exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution or is otherwise made confidential by law. Copies of such reports shall be retained in the records of the provider for at least 3 years following the date the reports are filed and issued, regardless of a change of ownership. (b) A licensee shall, upon the request of any person who has completed a written application with intent to be admitted by such provider, any person who is a client of such provider, or any relative, spouse, or guardian of any such person, furnish to the requester a copy of the last inspection report pertaining to the licensed provider that was issued by the agency or by an accrediting organization if such report is used in lieu of a licensure inspection.	CZ824		

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CZ824	Continued From page 6 59A-35.120 Inspections. (1) When regulatory violations are identified by the Agency: (a) Deficiencies must be corrected within 30 days of the date the Agency sends the deficiency notice to the provider, unless an alternative timeframe is required or approved by the Agency. (b) The Agency may conduct an unannounced follow-up inspection or off-site review to verify correction of deficiencies at any time. (2) If an inspection is completed through off-site record review, any records requested by the Agency in conjunction with the review, must be received within 7 days of request and provided at no cost to the Agency. Each licensee shall maintain the records including medical and treatment records of a client and provide access to the Agency. (3) Providers that are exempt from Agency inspections due to accreditation oversight as prescribed in authorizing statutes must provide: (a) Documentation from the accrediting agency including the name of the accrediting agency, the beginning and expiration dates of the provider's accreditation, accreditation status and type must be submitted at the time of license application, or within 21 days of accreditation. (b) Documentation of each accreditation inspection including the accreditation organization's report of findings, the provider's response and the final determination must be submitted within 21 days of final determination or the provider is no longer exempt from Agency inspection. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to correct deficiencies within 30 days after being notified were identified	CZ824		

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CZ824	Continued From page 7 of inspection results. Findings included: Admission- Continued Residency: During a complaint investigation conducted on and concluded on , 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. During a revisit to a complaint investigation conducted on and concluded on , the facility failed to ensure the appropriateness of continued residency of one of 17 sampled residents, (Resident #3). Resident 3 exhibited changes on ambulation for weeks since the month of , and the facility did not do an assessment to the resident. Resident Care- Supervision: During a complaint investigation conducted on and concluded on , 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	CZ824		

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CZ824	Continued From page 8 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). During a revisit to a complaint investigation conducted on . . . . . and concluded on , the facility failed to safe guard residents' well-being by failing to follow current control standards related to COVID-19 and Florida Governor's emergency orders DEM Order 20-006, dated , delineating minimum screening standards for persons entering identified residential facilities for eight out of 17 sampled residents (#2, #4, #6, #7, #8, #9, #10, and #11). The facility failed to maintain updated written record of any significant changes or situation of for three out of 17 sampled residents (#3, #16, and #17). No one knew how or when Resident #3 suffered physical injuries. Resident Care- Arrangement for Health Care: During a complaint investigation conducted on and concluded on , 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 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 . . . . . . During a revisit to a complaint investigation conducted on . . . . . and concluded on , the facility failed to assist with the arrangement of healthcare services for two out 17 sampled residents (#16 and #3). Resident #16	CZ824		

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CZ824	Continued From page 9 exhibited changes in his behavior during the entire month of , as evidenced by aggressive behavior towards staff, from the facility and expressing . Resident #3 and arrived to the hospital the next day with a with hematoma and , and to the right , and right . Medication- Assistance with Self-Administration: During a complaint investigation conducted on and concluded on , 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 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. During a revisit to a complaint investigation conducted on and concluded on ,the facility to ensure that residents received the assistant with self-administration of medications within one hour before or one hour after the scheduled time for one out of 17 sampled residents (Resident #4). Medication- Records: During a complaint investigation conducted on and	CZ824		

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CZ824	Continued From page 10 concluded on . . . . . , 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 . . , 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 out of 15 sampled residents (#1, #2, #4, #5, #6, #7, #8, #9, #10 and #11). During a revisit to a complaint investigation conducted on and concluded on . . , the facility failed to ensure that Residents' MORs included the , the name of the resident's health care provider and the health care provider's telephone number for three out of 17 sampled residents (Residents #4, #8 and #9). Staffing Standards- Levels: During a complaint investigation conducted on . . . . . and concluded on , 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. During a revisit to a complaint investigation conducted on . and concluded on	CZ824		

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CZ824	Continued From page 11 . . . . . , the facility failed to have an accurate staff schedule that showed current staff providing care and services to the residents. Training- Staff In-Service: During a complaint investigation conducted on and concluded on . . . . . , 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). During a revisit to a complaint investigation conducted on . . . . . and concluded on , the facility failed to ensure that staff had at least 2 hours preservice orientation for two out of 10 sampled staff (Staff F and J). Physical Plant- Safe Living Environ/other: During a complaint investigation conducted on and concluded on , the facility failed to provide a clean and safe living environment free of hazards. During a revisit to a complaint investigation conducted on and concluded on . . . . . , the facility failed to have furniture in good working condition and to provide safe living environment. Records- Facility: During a complaint investigation conducted on and concluded on . . . . . , the facility failed to have an updated admission and discharge log that identified the facility or home address to which the resident was discharged. During a revisit to a complaint investigation conducted on and concluded on . . . . . , the facility failed to have an updated admission and discharge log that identified the	CZ824		

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CZ824	Continued From page 12 facility or home address to which the resident was discharged for one out of 17 sampled residents (#5). Records- Resident: During a complaint investigation conducted on [redacted] and concluded on [redacted], the facility 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). During a revisit to a complaint investigation conducted on [redacted] and concluded on [redacted], the facility failed to have an accurate health assessment form (AHCA form 1823) for two out of 17 sampled residents (#2, and #16). The current health assessments for Residents #2 and #16 had incomplete medical history and diagnoses while Resident #2's health assessment showed that he needed 24-hour nursing or [redacted] care. Risk Mgmt & QA; Adverse Incident Report: During a complaint investigation conducted on [redacted] and concluded on [redacted], 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). During a revisit to a complaint investigation conducted on [redacted] and concluded on [redacted], 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 (#3, #15, #14, #5, #13,	CZ824		

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CZ824	Continued From page 13 and #12). Background Screening- Compliance Attestation: During a complaint investigation conducted on [redacted] and concluded on [redacted], 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). During a revisit to a complaint investigation conducted on [redacted] and concluded on [redacted], 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 screening for one out of 10 sampled staff (Staff F). A review of records and interviews conducted on [redacted] showed that the facility had uncorrected deficiencies in admission continued residency, resident care supervision, arrangement for health care, assistance with self-administration, medication records, staffing standards levels, training staff in-service, physical plant safe living environment, records facility, records resident, adverse incident report and background screening compliance attestation: Interviews and record reviews on [redacted] and concluded on [redacted] showed that the facility had not corrected those deficiencies within the timeline. Unclassified	CZ824		

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{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 [illegible]; 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 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 [illegible]. (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	{A 160}		

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{A 160}	Continued From page 1 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. (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.	{A 160}		

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{A 160}	Continued From page 2 (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 for one out of 17 sampled residents (#5). Findings included: Review of the admission and discharge log showed that the facility discharged Resident #5 on . During an interview on at 6:47 AM, Staff C stated that Resident #5 left with his mother. In an interview completed on at 12:25 PM, Staff A stated that she did not know she needed to indicate the address where the resident was discharged to. Uncorrected Class III	{A 160}		
{A 162} SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include:	{A 162}		

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

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{A 162}	Continued From page 4	{A 162}		

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 plan and other documentation that the resident is

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{A 162}	Continued From page 5 a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's [redacted], 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 failed to have an accurate health assessment	{A 162}		

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{A 162}	Continued From page 6 form (AHCA form 1823) for two out of 17 sampled residents (#2, and #16). The current health assessments for Residents #2 and #16 had incomplete medical history and diagnoses while Resident #2's health assessment showed that he needed 24-hour nursing or , , care. Findings included: Review of Resident #2's record showed that were discharged papers from a local hospital dated . The hospital record showed that the resident was discharged from the hospital on with discharge diagnoses of rhinovirus and , . The hospital discharged papers showed the resident needed to follow up with the primary care provider within one (1) week. The hospital sent a health assessment form (AHCA form 1823) which showed under special precautions that the resident needed to wear surgical mask for 6 days. The form showed that the resident had a communicable which could be transmitted to other residents or staff, rhinovirus. Review of Resident #2's record showed that there was a health assessment form (AHCA form 1823) completed on . The form showed under section C that the resident pose a danger to self or others due to his current mental status and that the resident required 24-hour nursing or , , care. The resident had medical history and diagnosis of , and was disorganized baseline and decline. 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	{A 162}		

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{A 162}	Continued From page 7 and . 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 for Resident #2. The court document indicated that the resident had , non-compliance with medications, poor insight and judgment, , and responding to internal stimuli. Review of Resident #16's record showed the admission date on . The health assessment (AHCA Form 1823) completed on just showed as the resident's medical history and diagnoses. The health assessment showed that the residents behavioral status was congruent with mental illness. The resident was independent with all activities of daily living. The resident had a regular diet. The resident needed assistance with self-administration of medication and was not considered an elopement risk. Further review of Resident #16's record showed he was admitted to a local hospital after being because he was agitated and threatening and non-compliant with medications on . The evaluation completed to the resident at the hospital on showed that he had medical history and diagnoses of , , , gunshot , , homelessness, drug- intensive care , , use, discomfort in , , agitation,	{A 162}		

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{A 162}	Continued From page 8 aggression, . . , ... , and . . . . The resident was diagnosed with acute , at the time of discharge. During an interview on . . . . . at 12:28 PM with the administrator, she stated not being aware that Resident #2 needed 24-hour nursing or , , ... care. The administrator added the facility submitted the plan of correction to the agency on . . Uncorrected Class III	{A 162}		
{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 . . . . . ;	{A 165}		

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{A 165}	Continued From page 9 4. . . . . or . . . . . of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency 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	{A 165}		

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

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{A 165}	Continued From page 11 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 (#3, #15, #14, #5, #13, and #12). Findings included: Review of adverse incident report database showed that the facility did not submit any adverse incident report to AHCA for Residents #3, #15, #14, #5, #13, and #12. Review of Resident #3's record showed that there were hospital discharge papers for , . The discharge summary indicated, under the chief complaint, Resident #3 was hospitalized under 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 police report showed that the facility contacted the police on 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 , . Review of police report showed that Resident #14 was hospitalized under on .	{A 165}		

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{A 165}	Continued From page 12 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 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 [redacted]. Review of police report showed that Resident #5 was hospitalized under [redacted] on [redacted]. 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 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].	{A 165}		

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{A 165}	Continued From page 13 Review of police report showed that Resident #12 was hospitalized under [redacted] on [redacted] and on [redacted]. The facility contacted the police on [redacted] 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 [redacted] of the [redacted] and wanted to go [redacted] to see his father. The resident was disoriented to time, place and person. The resident was hospitalized under [redacted]. On [redacted] at 2:36 PM, the facility contacted the police 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]. During an interview on [redacted] at 12:32 PM with the administrator, she stated that the facility submitted the required adverse incident reports. The facility sent the corrections to AHCA field office on [redacted]. Uncorrected Class III	{A 165}		
{A 000}	Initial Comments A revisit to a complaint investigation (complaint number 2020002505) was conducted at Sara Home Care on [redacted] and concluded on [redacted]. Deficiencies were identified at the time of the survey.	{A 000}		

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{A 010} SS=J	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. (9) A , 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.	{A 010}		

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{A 010}	Continued From page 15 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 [illegible]-to-[illegible] 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 30 days, as documented by a health care provider, the resident must be discharged from the facility. (c) A [illegible] 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	{A 010}		

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{A 010}	Continued From page 16 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. 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 two of 17 sampled residents, (Resident #3, Resident #12). Resident #3 was unable to walk for at least three months before he , acquired on his and the left side of his body, and was hospitalized. Resident	{A 010}		

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{A 010}	Continued From page 17 #12 assaulted Resident #3 and was hospitalized briefly, returning to live in the facility without further assessment or intervention for another two months before becoming violent and threatening again. Findings included: A review of hospital records for Resident #3 showed that he was admitted on at least three different occasions since . According to the hospital record, the resident was not ambulatory and could not transfer. During the last hospitalization on , Resident #3 was frail, and listless. The resident had a , a hematoma on the right side of the of plus to the right , right and ride side of the . The resident was not oriented to place, time or situation and he was slow to respond and . The diagnoses were unspecified abnormalities of gait and mobility, history of falling, of other part of and adult . Further review showed Resident #3 arrived at the emergency department via Emergency Medical Services with complaints of general and not eating. The facility sent the resident because he refused to eat or get out of bed since the day before. The resident had , and he had been discharged from the hospital the previous week. Further hospital record review showed that Resident #3 was hospitalized at least three times between , and . During an interview on , the administrator stated, regarding the hospitalization, that Resident #3 'collided with' another resident, and hit his '. However, a review of the facility's records showed that on	{A 010}		

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{A 010}	Continued From page 18 . . . . . showed Resident #3 went by himself to smoke on the porch, and . Further review of facility records showed that on . . . . . , the facility sent Resident #3 to the hospital because he refused to walk. Attempts to obtain further information from the administrator and staff about these incidents resulted in no clear information being provided. On , , at 6:30 AM during an onsite inspection, Staff C and J stated that there were eight residents at the facility and two at the hospital, including Resident #3. On , , ... at 6:43 AM, Staff C stated that Resident 3 was at the hospital since beginning of , due to issues with his balance. The staff denied any . On , . at 6:40 AM, Resident 9 stated, "Resident 3 is in the hospital, but I don't know why; I haven't heard anything about the condition. He could not walk, and they took him in an ambulance. He was on the floor at the living room, he was not screaming or crying, no one touched him until the ambulance came." On , ... at 11:57 AM, Staff G stated, "Resident #3 was on the porch smoking and . Resident 3 needed more care, he needed to be in a rehab or nursing home; he was too much for the staff; he needed one staff to just take care of him continuously. Maybe the resident got the scratches on the and the when he the day before. Review of facility and resident records revealed no documentation of the incident. On , . at 12:35 PM during a phone	{A 010}		

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{A 010}	Continued From page 19 interview with Resident's #3 family member, she stated, "He was sent to the hospital multiple times but, the hospital did not tell me he was hit. The doctor at the hospital never told me anything about injuries. The supervisor at the rehab place told me that on , he was refusing to eat, out of breath, weak with injuries on left side of , , hematoma on right ; this is what he read from the report." On , , at 3:55 PM during a phone call interview with Resident's 3 friend, she stated, "I am very close to where he lived, about 10 minutes. I used to pick him up all the time to take him to buy things or take him to eat. When I spoke to the rehab place where he is, the nurse told me that he had been there three times, the first time for not able to walk, but they said that they did not understand because he was walking fine. The second time at the hospital because of a ache and was sent home the same day. The third time because he was not stable, one day for observation and said that he needed 24 hrs. care." On , , at 12:10 PM, during a phone interview with the primary doctor for Resident 3, the doctor stated, "I always visited him at the facility together with my assistant. The last hospitalization that I have in record is on , when he left the hospital and was transferred to a rehabilitation center. I went to see him few days before he went to the hospital and he had an issue with balance when walking. According to the report from the hospital, he had . I do not remember what they told me at the facility; I have a lot of patients, but I have never been told that other residents have hit him or injured him."	{A 010}		

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{A 010}	Continued From page 20 Review of progress notes and observation logs for Resident #3 showed that the facility documented he'd needed higher level of care since . The notes also documented that two staff were not enough to assist him with his activities of daily living. Further review of Resident #3's record showed admission on . He had no elopement history documented and was not identified as an elopement risk. A health assessment dated showed no and diagnoses of , , Prostatic Hyperplasia, and . The resident, who presented with gait imbalance and memory loss, needed universal precautions . The resident needed assistance with ambulation, bathing, self-care, toileting and transferring while needed supervision with eating. The resident had no added salt as special diet. According to the health assessment the resident's needs could be met in an assisted living facility. The resident needed assistance with self-administration of medications. Review of Resident #3's record showed a letter dated attention to his sister, informing her that they had sent the resident again to the hospital. The letter stated that the resident was deteriorating very fast and was not able to take care of himself. The facility emphasized in the letter the recommendation of moving the resident to a facility where more care could be provided due to the resident not meeting the criteria for continue living in an Assisted Living Facility. Further record review showed: - - The facility's owner spoke to someone from the nursing home where the resident lived. The resident would not return to the facility (ALF).	{A 010}		

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{A 010}	Continued From page 21 - [redacted] - The resident 'sister informed the nursing home that the resident would not return to the facility. The nursing home staff was informed that the facility issued a 45 day-notice to resident for moving out of the facility. The nursing home staff was provided with the owner's information and the owner was informed. - [redacted] - the facility called the ambulance because the resident did not want to walk. The resident required two staff to hold him or to transfer, and he was sent to the hospital. - [redacted] - The resident did not want to walk and did not want to cooperate (help). The resident required two staff members to help with transfers. The facility did not have a lifter and the situation affected the staff. "It was maddening with him". The resident needed another place for his recovery. The staff informed the owner because the staff was tired and [redacted]. A nursing home would be the best place for him due to his condition and for staff not being hurt. - [redacted] - When the staff arrived at the shift at 7:00 AM, they found that the resident did not want to walk. "It makes really difficult because there was not a lifter, the resident was transferred with the staff's arms. It was exhausting because the resident very tall and [redacted] a lot". The record further stated that the staff were tired and [redacted] from trying to lift the resident. - [redacted] - The resident continued with difficulty when walking. The resident wanted to go to the dining room and was found seated on the table eating one of the placemats. The staff had to take it out of his [redacted]. The resident had difficulty transferring. - [redacted] - The resident went to smoke on the porch and [redacted]. The staff called 911 (emergency services) immediately and they checked on him. - [redacted] - When the new shift started, the staff was informed that the resident had	{A 010}		

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{A 010}	Continued From page 22	{A 010}		

difficulties walking and . . The facility called 911 (emergency services) who went to the facility, checked the resident and did not find injury. During the afternoon the resident was kept in observation and continued with difficulty on ambulating. The resident ambulated when accompanied by a staff because he walked holding the walls and going to the sides. When the resident woke up in the morning, he was not able to get out of bed, even though the staff attempted to help, the resident continued with gait problems. The resident was not able to keep himself over his . . . (to remain standup). The resident attempted to get up and . The staff kept the resident in bed and checked on him frequently.

- . . . . . - The resident need to be redirected as he was disoriented. The resident did not know the locations of things in the house. The resident required staff to take him to the room while held his . . . because he walked holding the walls and got in other residents' beds. The resident was not able to take his medications to the .

- . . . . . - It was reported that the resident had difficulties walking by himself. The resident was disoriented and required continuous redirection.

- - It was reported that the resident continued presenting difficulties with walking. The resident required being directed to his room while staff held his . . . because he held the walls and the staff was afraid that he would . The resident woke up and the bed was soaked with .

Additional review of hospital records showed that Resident #3 was admitted to the hospital on and discharged on to a rehabilitation center. The diagnosis was listed as unspecified . The resident was

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{A 010}	Continued From page 23 identified as non-ambulatory. At the time of discharge the resident was disoriented to person, place and time and needed help with all activities of daily living (ADL). He was discharged to a rehabilitation center before returning to the assisted living facility. There was no documentation of when the resident returned. A review of hospital records for Resident #3 dated showed the resident arrived at the emergency department via Emergency Medical Services ( ) with complaints of Altered Behavior and . The ambulance record showed that the resident showed signs of severe . Medical evaluation showed that the resident was , delirious and with , judgement/insight, and the he was admitted on the , , unit under a (The is a Florida law that enables emergency mental health services and temporary detention for people who are , because of their mental illness, and who are unable to determine their needs for treatment). According to the physician's evaluation documented in the hospital record, there was a substantial likelihood that without care or treatment , Resident #3 would cause serious harm to self and others as evidence of being aggressive with the assisted living facility 'staff and residents plus refusing taking his medications. The hospital record further showed that the resident was disoriented and was not aware of himself, those around him, his location, the date or time (this state is called 'oriented times zero', according to a description of the mental status examination at Brown University). The , , doctor's notes on showed that the resident functional level declined and needed supervision and some support in his activities of daily living. Admitted to the , , units after being aggressive to	{A 010}		

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{A 010}	Continued From page 24	{A 010}		

other people and refused to take medication. The resident had important decline in his physical motor activity, was not able to walk by himself, very dependent and very demanding. The resident was not oriented to place, time or situation. On while on the , unit in the hospital, he was transferred to the emergency room due to abnormal labs and for further evaluations. The resident was diagnosed with , and had , and .

An additional review of Resident # 3's hospital records showed an admission on and discharge the same date. Diagnosis: . Arrived at the emergency department via with complaints of general on at 12:44 PM. The resident was alert but . No recent hospitalizations reported at that time. Past medical history showed , , multiple of right-side and illness. Physical examination did not show any physical (visible) . The resident was discharged the same day to the facility at 1:56 PM and left the hospital at 4:31 PM. The hospital representative spoke with the facility's staff E who informed them that the resident woke up with unsteady gait.

2)

A review of facility records showed that Resident #12 assaulted Resident #3 by hitting him in the on . Resident #12 was taken by police to a crisis unit under a .

During an interview on , a friend of Resident #3 stated that she and the resident were beaten by another resident in .

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{A 010}	Continued From page 25 Review of a date-stamped video of the incident received from the friend showed, after she arrived at the facility to meet with Resident #3, an unseen person walked up, the friend screamed, and the camera to the ground (video evidence obtained). Staff were seen running away toward the of the facility saying " Give me the phone, I'm going to to call the police." When interviewed, the friend said that a resident pushed her out of the way and 'sucker punched' Resident #3. Review of a document presented by the facility (not an incident report or a progress note) showed that on at 5 pm, Resident # 11 Resident #3 by hitting him in the . According to the document, 911 was called and they checked Resident #3 and left him there; the police took Resident #12 to the hospital. A review of the police report showed no documentation of the assault, stating only that Resident #121 was taken to a crisis center for treatment. There was no documentation that emergency medical services had been onsite or had assessed Resident #3. There was no documentation of a follow up consult with a physician to assess Resident #3 after the event. Record review showed that Resident #12 returned to the facility after hospitalization, living there until , when he was hospitalized after being aggressive, causing staff and residents to hide in the facility until the police arrived to hospitalize him under the . There was no documentation of any safety measures put in place to protect the other residents between the and incidents. During an interview on two facility	{A 010}		

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{A 010}	Continued From page 26 staff members, stated that the Resident #3 had an incident with the Resident #12 in . Resident #12 pushed Resident #3 because Resident #3 walked too fast and did not pay attention to the surroundings. The staff members stated that the facility called emergency services. Uncorrected Class I	{A 010}		
{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,	{A 025}		

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{A 025}	Continued From page 27 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. (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 safeguard eight out of 17 sampled residents from exposure to COVID-19, a potentially life threatening illness caused by exposure to a Coronavirus. The facility failed to safe guard residents' well-being by failing to follow current control standards related to and Florida Governor's emergency orders DEM Order 20-006, dated , , delineating minimum screening standards for persons entering identified residential facilities (Residents #2, #4, #6, #7, #8, #9, #10, and #11). The facility also failed to provide supervision, care and services appropriate to the needs of Resident #3, #12 and #16. Resident #3's health declined and the resident and was hospitalized with a , hematoma and to the , and to the right , and right	{A 025}		

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{A 025}	Continued From page 28 . . . . . The facility was unable to explain the injuries. Resident # 12 hit another resident and returned to live at the site for another two months. Resident #16 exhibited changes in behavior during the month of , including aggressive behavior towards staff, and from the facility, with no documented intervention provided. Findings Included: 1. The COVID-19 is a transmissible , that presents severe risk to persons who are aged, infirm, or suffer from co- including, but not limited to, system deficiency, , , , and . See generally, Publications of the Centers for Control (CDC). On , the Governor of the State of Florida issued Executive Order 20-51 designating a Public Health Emergency as a result of COVID-19 and its impact. Pursuant to that authority, emergency orders have been issued by the Florida Division of Emergency Management to implement the protections necessary to assure the health, safety, and well-being of Florida's citizenry, including those most to the effects of . Among those emergency orders was DEM Order 20-006, dated , , delineating minimum screening standards for persons entering identified residential facilities. The Agency for Health Care Administration (AHCA) has issued guidance and clarification on DEM Order 20-006 to providers, and on , issued an alert notifying nursing homes that all staff or other individuals admitted to a	{A 025}		

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{A 025}	Continued From page 29 residential facility must don masks and that caregivers must wear gloves when providing resident care. While the treatment and management of residents with and the implementation of isolation precautions for such events are a long-standing health care issues faced by residential facilities, the ease of contagion and the effects of presented by COVID-19 mandate that providers exert meticulous practice and procedure to identify resident symptoms and take immediate procedures to both assure appropriate treatment of a potentially resident and protect the remainder of a facility's population from the risk of spread of the . Observation on at 6:39 AM showed that Staff C and D were on duty taking care of eight residents (Residents #2, #4, #6, #7, #8, #9, #10, and #11). The staff allowed three visitors in the facility. The staff did not screen visitors before entering the facility. According to Centers for Control and Prevention (CDC) the healthcare facilities should limit the visitors due to the COVID-19 pandemic, regardless of known community transmission. Only visitors essential should be allowed and screened before entering the healthcare facility for symptoms of acute illness consistent with COVID-19. Wear cloth coverings in any shared spaces, not including your room. Ensure residents who must leave the facility (e.g., residents receiving) wear their cloth covering whenever leaving the facility. Work to implement social distancing among residents. Social distancing means people remain at least 6 apart to limit potential for transmission.	{A 025}		

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{A 025}	Continued From page 30 Observed on . . . . . at 6:39 AM during the tour of the facility that none of the residents wore . . . . masks or cloth . . . covering. Resident #2 was not in his room and ambulated around the facility without wearing . . . masks or . . . . covering. Residents #7 and #10 observed sitting next to each other on the love seat in the living room without a distance of six between them and did not wear . . . masks. Observation on . . . . . at 6:48 AM showed that Staff G arrived to the facility. While Staff G walked into the building, she talked to Staff C and J stating, "Did you check their temperature? Did they sign in the visitor log?". Staff C and J denied checking the temperature to visitors or completing the screening regarding COVID-19. Staff G stated, "Do it now!". Observation on at 6:59 AM, Staff E arrived to the facility. Staff C, G, or J did not screen Staff E regarding COVID-19 or checked her temperature. Observation on . . . . . at 8:10 AM showed that Resident #2 did not wear mask or cloth. On further observation at 8:11 AM, Resident #2 boarded a bus that would transport him to a day program. Resident #2 observed not wearing anything to cover his or . On at 8:12 AM the facility was instructed by one of the Agency representatives to give a mask or clothe to Resident #2 for covering his . . . or . . . before leaving. During an interview on . . . . . at 8:12 AM with Staff G stated, " Resident #2 left his mask every day".	{A 025}		

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{A 025}	Continued From page 31 During an interview on [redacted] at 8:18 AM, the administrator stated that she took the information out of CDC or DOH regarding the COVID-19. The facility supervised the residents for any [redacted], [redacted], problems and the temperature. The staff must wash their [redacted] and wear mask at all times. The staff must ensure that residents kept the social distancing of 6 between residents. During an interview on [redacted] at 8:29 AM with Staff G, she stated that the facility had a protocol to follow when someone arrived. The staff added that the protocol was for visitors and staff for washing their [redacted], using [redacted] sanitizer, checking the temperature and record it, plus the use [redacted] mask. The protocol also included to screen visitors or staff at the time of arrival with questions about having [redacted], feeling bad, or travel history and also if any of those were applicable to their close family. Staff G said that the facility reinforced the washing with residents, allowed residents to eat in their rooms, and the residents who ate in the dining room needed to keep enough distance between them. Observation on [redacted] at 8:46 AM showed Residents #9 and #7 sat on a love seat next to each other in the living room within six between them. During an interview on [redacted] at 8:46 AM, the administrator stated that the facility did not have written policy and procedures for [redacted] control. Review of facility's record showed that the facility did not have written policy and procedures for [redacted] control.	{A 025}		

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{A 025}	Continued From page 32 Review of facility's record showed that none of the staff recorded their names at the arrival time. The facility did not have record about any screening completed. Review of facility's record showed that the facility had educative materials in Spanish and English for COVID-19. The facility posted the Governor's emergency order but there was no documentation about the implementation. Review of the progress notes for Resident #2 showed that on the night the facility sent the resident to the hospital due to , , problems and , , . Review of Resident #2's record showed discharged papers from a local hospital dated . The hospital record showed that the resident was discharged from the hospital on with diagnoses of rhinovirus and . The hospital records showed the resident needed to follow up with the primary care provider within one (1) week. The hospital sent a health assessment form (AHCA form 1823) which showed under special precautions that the resident needed to wear surgical mask for 6 days. The form showed that the resident had a communicable which could be transmitted to other residents or staff, rhinovirus. According to Resident #2's hospital records, acquired , is an of the which can cause in the airways of the and build up and fluid inside the airways. In order to treat, it could require among treatments the use of a machine to help the person to breath or having a procedure to remove fluids from around the . Acquired	{A 025}		

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{A 025}	Continued From page 33 , ... can be caused by germs breathed in droplets from the , or sneeze of an person. During an interview on . . . . . at 12:27 PM with Staff G, she stated she was not aware if Resident #2 was tested for COVID-19. Review of Resident #2's record showed that there was no documentation indicating that the resident received a follow up with the primary care provider within one (1) week. There was no indication the facility made any effort to determine if the resident was COVID-19 negative or to provide protection to other residents or staff. 2. Review of Resident #3's record showed that he went to hospital and been hospitalized at least on three different occasions. The hospital records indicated that the resident was not ambulatory, could not transfer and was disoriented to time, place and situation. The resident went to the hospital on . . . . . and had a . . . , a mild hematoma on the right side of the . . . of the . . . and . . . . . to the right , right , and right side of the at the time of arrival to the hospital. Review of progress notes for Resident #3 showed: - On . . . . . , the resident continued with difficulty walking and transferring. He is disoriented and often needs redirection. The resident was sitting at a table and eating one of the placemats. The resident was walking outside and tripped over his and felled. - On , the facility sent the resident to the hospital because he did not want to walk.	{A 025}		

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{A 025}	Continued From page 34 Further review of progress notes and observation log for Resident #3 showed that the facility documented he needed higher level of care since , . They also documented that two staff were not enough for assisting him with his activities of daily living. The staff felt tired and hurt of taking care of Resident #3 because he needed too much help with his activities of daily living specially ambulation and transferring. The staff documented in multiple entries being scared that Resident #3 could . . During an interview on . . . . . at 6:43 AM, Staff C stated that Resident #3 was at the hospital since beginning of , ... due to he presented problems with his balance. The staff denied that the resident . . During an interview on . . . . . at 6:54 AM with Staff J, the staff denied that any resident had . . . at the facility and denied that there were any fights between residents or between residents and staff. During an interview on . . . . . at 7:00 AM with Staff C, the staff denied that any resident had . . . at the facility and denied that there were any fights between residents or between residents and staff. During an interview on . . . . . at 7:07 AM with the Staff E, she stated not recalling any elopements, any fights, any . . or any physical aggression between residents, staff to residents or residents to staff. During an interview with the administrator on at 7:15 AM, she denied that any resident or staff was physical aggressive to Resident #3.	{A 025}		

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{A 025}	Continued From page 35 During an interview on at 8:07 AM with Staff G, the staff stated that none of the residents at the facility and no resident or staff was physically aggressive to Resident #3. On a further interview at 9 AM, the staff added that no resident in the facility. After the staff been questioned specifically about Resident #3, she stated that Resident #3 just on . The facility sent the resident to the hospital the following day but he did not have any skin problems when he resident left to the hospital. The staff denied that the resident had any scratch or skin discoloration at the time he left. During an interview on at 7:55 AM with Staff E, she stated that Resident #12 got aggressive with Resident #3. The staff called the police who took Resident #12 under custody and he did not return to the facility. The staff added that Staff D was on duty with her the day of the incident. During an interview on at 8:15 AM with Staff D, she stated that Resident #12 was aggressive. Resident #12 pushed Resident #3 and if Resident #12 would have hit Resident #3, he would have killed him. That incident was a while ago. During an interview on at 1:20 PM by telephone, with the Administrator, she stated Resident #3 collided or got tangled up with another resident and the staff found Resident #3 on the floor. The Administrator stated, "I don't remember the dates, I was not there when this happen." She stated, "the staff write problems in a book and I read what is written in the book." Review of facility's records showed Resident #3	{A 025}		

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{A 025}	Continued From page 36 had no documentation of the collided/tangled up incidents mentioned by the Administrator. Review of facility's records showed that on [redacted] at 5:00 PM, Resident #12 assaulted Resident #3 by hitting him on the [redacted] not causing major injuries. Resident #12 was [redacted] by the police. Staff C and D and a friend of Resident #3's family witness the incident. During an interview on [redacted] at 3:55 PM, a friend of Resident #3 informed a resident from the facility beat Resident #3 and herself. That resident pushed her out of the way and 'sucker punched' Resident #3. Review of a date-stamped video of the incident received from Resident #3's sister showed that after Resident #3's friend arrived at the facility and met with Resident #3, an unseen person walked up, Resident #3's friend screamed, and the camera [redacted] to the ground. Staff were seen running away toward the [redacted] of the facility saying, " Give me the phone, I'm going to call the police." Review of police report showed that Resident #12 was hospitalized under [redacted] on [redacted] and on [redacted]. The police report showed no documentation of the assault, stating only that Resident #12 was taken to a crisis center for treatment. There was no documentation that emergency medical services had been onsite or had assessed Resident #3. Review of Resident #3's record showed that there was no documentation of a follow up consult with a physician to assess Resident #3 after the event on [redacted]	{A 025}		

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{A 025}	Continued From page 37 Review of facility's records showed that on , Resident #12 who was in the facility since unknown date, was aggressive, screaming and saying that he wanted to assault anyone. The incident caused staff and residents to hide in the facility until the police arrived to Resident #12. There was no documentation of any safety measures put in place to protect the other residents between the and incidents. During an interview on at 11:47 AM with Staff D, she stated that Resident #3 needed total assistance with his activities of daily living. The resident did not in the facility he just slipped. The resident went to the porch for smoking and slipped. The staff picked him up, assisted resident to the living room area and placed him on chair. Resident #12 pushed Resident #3 and the facility called the police but it happened around . Resident #3's friend witnessed the incident of . During an interview on at 11:57 AM with Staff G, she stated being told by other staff that Resident #12 pushed Resident #3. Resident #12 was at the hospital because the police him after having aggressive behavior. On , Resident #3 was in the porch smoking and . Resident #3 needed more care, he needed to be in a rehab or nursing home; he was too much for the staff. The resident just one staff that took care just of him continuously. The staff added that maybe the resident got the scratches on the and the when he the day before. Review of progress notes for Resident #3 showed that on the resident continued presenting difficulties with the ambulation. The	{A 025}		

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{A 025}	Continued From page 38 resident required being directed to his room while holding his because he held from the walls and the staff was scare that he could . The resident woke up and the bed was wet with . During an interview on at 11:57 AM with Staff G, she also stated that Resident #3 returned from the rehabilitation center on . The progress note dated was a mistake, maybe the staff referred to . During an interview on at 6:42 AM, Staff C stated that Resident #16 was at the hospital since previous Sunday ( ). The staff added that the resident talked with his case manager and the resident informed the case manager about committing . Review of the facility's internal incident report showed that Resident #16 from the facility on and the law enforcement returned him to the facility later on the day. Review of Resident #16's record and the facility's records showed that there was no indication that the resident was at risk for elopement, that the facility completed any assessment for elopement risk after the event, or that the facility implemented any interventions to minimize the risk of the resident's future elopement. During an interview with Resident #16's case manager on at 12:13 PM she stated the resident has a history of from every facility he has been placed. This is the longest time he has stayed in one facility. During an interview on at 11:47 AM with Staff D, she stated she was working when	{A 025}		

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SARA HOME CARE	29100 SW 172 AVENUE HOMESTEAD, FL 33030

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{A 025}	Continued From page 39 Resident #16 . . . . . from the facility on . The resident woke up and was agitated but he calmed down. Resident #16 became agitated again after lunch. The resident was continuously saying that he wanted to leave. The resident broke the mesh from the door and walked out of the facility. Staff D walked behind him, she lost him from her watch and returned to the facility for calling the police. The police returned the resident. During an interview on at 12:32 PM Staff A stated she was not aware of Resident #16's history and she was assured by their case manager that he would not elope. During an interview on . . . . . at 6:54 AM with the Staff J, she stated being aware about one elopement during the month of , and was Resident #16. The staff stated that the resident eloped and the staff called the police. According to a phone call to the police department on at 9:09 AM, the police records showed that the only phone call made from the facility in the month of , was on , . . . for an attempted . . . . . by Resident #16, but no report was written. During an interview on at 12:28 PM with Staff G, she stated that Resident #16 was on because he did not listen and was jumping and pushing thru the air like being boxing. The resident eloped the day before from the facility after asking the staff for leaving the facility. On the day of the elopement, the staff on duty asked Resident #16 for signing on the logbook but the resident refused to do it and left. The facility called the police who brought the resident to the facility later on the day.	{A 025}		

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{A 025}	Continued From page 40 Review of adverse incident report database for the facility showed that the facility filed an adverse incident report on because Resident #16 eloped from the facility on . . . . . On the adverse incident report the facility stated that Resident #16 left the facility on . . . . . around 6:45 PM and the police returned him to the facility around 2:30 AM. The resident who was aggressive, was also new resident at the facility. On . . . . . , Resident #16 was very aggressive with the personnel and out control. On . . . . . at 1:42 PM, Staff B called and informed the resident's representative about the resident's aggressive and elopement condition. Uncorrected Class I	{A 025}		
{A 027} SS=J	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:	{A 027}		

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{A 027}	Continued From page 41 Based on record review and interview, the facility failed to assist with the arrangement of healthcare services for two out 17 sampled residents (#16 and #3). Resident #16 exhibited changes in his behavior during the entire month of , as evidenced by aggressive behavior towards staff, , from the facility and expressing . Resident #3 and arrived to the hospital the next day with a , hematoma and to the , and to the right , and right . Findings included: 1) Review of Resident #16's record showed the admission date on . The health assessment (AHCA Form 1823) completed on just showed , as the resident's medical history and diagnoses. The health assessment showed that the resident's behavioral status was congruent with mental illness. The resident was independent with all activities of daily living. The resident had a regular diet. The resident needed assistance with self-administration of medication and was not considered an elopement risk. Further review of Resident #16's record showed he was admitted to Jackson Behavioral Health under a due to being agitated and threatening and non-compliant with medications. Resident #16 was admitted to the hospital from to . The discharge summary from the hospitalization revealed Resident #16 arrived at the hospital as a result of a . The resident presented with agitation/violent behavior. The resident had an evaluation completed on and it showed a medical history of ,	{A 027}		

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{A 027}	Continued From page 42 , agitation, aggression, , and . The resident was diagnosed with acute at the time of discharge. There were instructions indicating that Resident #16 needed to follow up with a psychiatrist and the was scheduled for . Review of Resident #16's facility record showed no documentation that the resident received follow up care with a psychiatrist. Review of Resident #16's facility record revealed that on the ambulance was called for the resident due to the resident being unstable on his and . Review of Resident #16's facility records revealed there was no documentation of a visit with a medical provider after the incident on or any documented observations of the resident's health status after that incident. Review of Resident #16's facility record revealed that on the resident was in , and could not get out of bed for breakfast. The resident went to the hospital via ambulance and returned him to the facility the same night. Review of Resident #16's facility records revealed there was no documentation that the resident received follow up care with a medical provider after this incident. In an interview with Resident #16's case manager on at 12:13 PM she stated one of the facility staff called her on informing her that Resident #16 was in , and the case manager recommended to the staff sending Resident #16 to the hospital.	{A 027}		

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{A 027}	Continued From page 43 Review of Resident #16's facility record revealed there was no documentation that the resident received follow up care with a primary care physician or psychiatrist. Review of facility's observation notes for Resident #16 revealed that the resident was exhibiting aggressive behavior on . Staff B contacted the resident's case manager about the aggressive behavior. On at 5:20 AM, the resident was aggressive with the staff by knocking on the refrigerator after the staff told the resident that he was not permitted inside of the kitchen. The observation notes showed that on , three days later, the facility informed the resident's case manager of the resident's aggressive behavior. In an interview with Resident #16's case manager on at 3:21 PM she stated she was not aware of any physical harm; she was told the resident was upset because he could not go inside of the fridge. Facility record review on showed an adverse incident report for Resident #16 on when the resident exhibited aggressive behavior and broke a mesh on the patio screen to from the facility. According to the adverse incident report, one of the facility staff called the police and the police returned the resident to the facility that same day. Review of Resident #16's observation notes revealed the facility informed the residents case manager of the resident from the facility. There was no documentation that the resident was seen by a medical care provider following this incident. Review of police report related to the call placed	{A 027}		

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{A 027}	Continued From page 44 by the facility on . . . . . at 4:05 PM because Resident #16 from the facility revealed that no police record was found. In an interview on . . . . . at 7:35 AM, Staff G stated that "We had to call the police for Resident #16 multiple times, but the police did not give us a police report number few of those times." In an interview with Resident #16's case manager on . . . . . at 12:13 PM she stated the resident had a history of from every facility he had been placed. This was the longest time he stayed in one facility. In an interview on at 12:32 PM the administrator stated she was not aware of Resident #16's history and she was assured by his case manager that he would not elope. Review of Resident #16's facility record showed a 45-day notice given on due to not meeting criteria at the facility due to being uncontrollable and violent, destroying business property, refusing to follow rules, and not following recommendations. Review of Resident #16's facility record showed Staff C spoke with the resident's case manager on and the resident's case manager advised Staff C to send the resident to the hospital after the resident expressed having . . . . . . Staff E called the police and the police called an ambulance to take the resident to the hospital. In an interview with Resident #16's case manager on at 12:13 PM she stated the resident did not express any . . . . . to her.	{A 027}		

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{A 027}	Continued From page 45 The facility's observation notes for Resident #16 revealed: - On . . . . . Staff E called the ambulance because the resident could not stand up and was . . . . . The ambulance got the resident at 10:15 PM and he was returned from the hospital to the facility at 3:36 AM. - On the resident was violent and aggressive expressing he did not want to be in the facility, and he wanted to go home. The resident sat on the locked front porch at 3:45 PM and broke the mesh on the patio screen and left the facility. Staff D contacted the police who returned the resident to the facility at 4:15 PM. There was no documentation indicating that the resident's primary care provider reevaluated the resident after any of those incidents. In an interview with Resident #16's case manager on . . . . . at 12:13 PM she stated the facility contacted her to take the resident to the psychiatrist on . . . . . The case manager informed them she could not come to the facility and take the resident herself and if they felt he was at risk they should send him to the hospital. There was no documentation showing that the resident received any medical care from the psychiatrist, instead the resident was hospitalized. Review of progress notes for Resident #16 revealed that there was no documentation indicating that the facility informed the resident's primary care provider of the changes in his behavior. There was no documentation about any interventions in place by the facility with Resident #16 after the resident from the facility on . There was no documentation that a physician evaluated him regarding the changes in	{A 027}		

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{A 027}	Continued From page 46 behavior from through . Review of Resident #3's record showed that he went to the hospital on and had a , a mild hematoma on the right side of the of the and to the right , right , and ride side of the at the time of arrival to the hospital. Review of progress notes for Resident #3 showed that on , the staff noted the resident having difficulty walking and transferring, and being disoriented but the staff let him go smoking to the porch where from his own . On , the facility sent the resident to the hospital because he did not want to walk. During an interview on at 6:54 AM with Staff J, the staff denied during the interview that any resident at the facility. During an interview on at 7:00 AM with Staff C, the staff denied during the interview that any resident at the facility. During an interview on at 7:07 AM with the Staff E, she stated not recalling that any resident . During an interview on at 8:07 AM with Staff G, the staff stated that none of the residents in the facility. During an interview on at 11:57 AM with Staff G, she stated that on , Resident #3 was in the porch smoking and . Resident #3 needed more care, he needed to be in a rehab or nursing home; he was too much for the staff. The resident just one staff that took care just of him continuously. The staff added that	{A 027}		

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{A 027}	Continued From page 47 maybe the resident got the scratches on the and the when he the day before. During an interview on at 7:55 AM with Staff E, she stated that Resident #12 got aggressive with Resident #3. The staff called the police who took Resident #12 under custody and he did not return to the facility. The staff added that Staff D was on duty with her the day of the incident. Review of facility's records showed that on at 5:00 PM, Resident #12 assaulted Resident #3 by hitting him on the not causing major injuries. The police Resident #12. Staff C and D and a friend of Resident #3's family witness the incident. During an interview on at 3:55 PM, a friend of Resident #3 informed a resident from the facility beat Resident #3 and herself. That resident pushed her out of the way and 'sucker punched' Resident #3. Review of a date-stamped video of the incident received from Resident #3's sister showed that after Resident #3's friend arrived at the facility and met with Resident #3, an unseen person walked up, Resident #3's friend screamed, and the camera to the ground. Staff were seen running away toward the of the facility saying " Give me the phone, I'm going to to call the police." Review of police report showed that Resident #12 was hospitalized under on and on . The police report showed no documentation of the assault, stating only that Resident #12 was taken to a crisis center for treatment. There was no documentation that	{A 027}		

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{A 027}	Continued From page 48 emergency medical services had been onsite or had assessed Resident #3. Review of Resident #3's record showed that there was no documentation of a follow up consult with a physician to assess Resident #3 after the event on . Uncorrected Class I	{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	{A 052}		

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{A 052}	Continued From page 49 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 prescribed 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 bags. (4) Assistance with self-administration does not include: (a) Mixing, converting, or 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 of the body. (d) Administration of preparations. (e) Irrigations or debriding agents used in the treatment of a skin condition. (f) , , or 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.	{A 052}		

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{A 052}	Continued From page 50 (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 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	{A 052}		

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{A 052}	Continued From page 51 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 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	{A 052}		

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{A 052}	Continued From page 52 medication. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility to ensure that residents received the assistant with self-administration of medications within one hour before or one hour after the scheduled time for one out of 17 sampled residents (Resident #4). Findings included: During an interview on at 6:39 AM with Staff C, she stated that there were eight residents in the facility who were Residents #2, #4, #6, #7, #8, #9, #10, and #11. The staff added at 6:47 AM that all residents at the facility already took their medications. Review of Resident #4's Medication Observation Records for the showed that there was an order for 500 mg tab with instructions of taking "one tablet by every morning and two tablets by at". The was scheduled at 8 AM and 8 PM. The dose for at 8 AM for 500 mg had the staff's initials as indication of given. During an interview on at 12:13 PM with the administrator, she stated that it was impossible the facility had uncorrected deficiencies related the medication. The administrator also stated that the facility had a nurse consultant who gave the training and the facility sent the corrections to the agency. Uncorrected Class III	{A 052}		

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{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 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 ␣ 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 , 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 ensure that Residents' Medication Observation Records (MORs) included the ␣ , the name of the resident's health care	{A 054}		

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{A 054}	Continued From page 54 provider and the health care provider's telephone number for three out of 17 sampled residents (Residents #4, #8 and #9). Findings included: Review of Residents #4, #8 and #9's MORs showed that having black the sections for the [illegible], the name of the resident's health care provider and the health care provider's telephone number. During an interview on [illegible] at 12:13 PM with the administrator, she stated that it was impossible the facility had uncorrected deficiencies related the medication. The administrator also stated that the facility had a nurse consultant who gave the training and the facility sent the corrections to the agency. Uncorrected Class III	{A 054}		
{A 079} SS=D	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 16-25 253 26-35 294 36-45 335 46-55 375 56-65 416	{A 079}		

{A 079}

Continued From page 55

{A 079}

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 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 .

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{A 079}	Continued From page 56 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 , 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, 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	{A 079}		

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{A 079}	Continued From page 57 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 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	{A 079}		

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{A 079}	Continued From page 58 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 an accurate staff schedule that showed current staff providing care and services to the residents. Findings included: Observation on . . . . . at 6:39 AM showed that Staff C and J worked at the facility and took care of eight residents. On further observation on at 6:48 AM, Staff G arrived while Staff D and E arrived to the facility at 6:59 AM. Staff A and B observed arriving and entering to the facility on . . . . . at 7:04 AM. Observation on . . . . . between 6:38 AM and 10 AM did not show that Staff E was not at the facility. Review of staff schedule for week of . . . . . to showed: - Staff G worked on Friday starting at 9 AM. - Staff D worked on Friday starting at 8 AM. - Staff C worked on Monday, Tuesday, Wednesday, and Friday from 6 PM to 7 AM. Staff C did not show on schedule during the night shift of Thursday.	{A 079}		

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{A 079}	Continued From page 59 - Staff F worked Monday, Wednesday, and Thursday from 5 PM to 8 AM, Saturday from 8 AM to 6 PM and Sunday from 7 AM to 5 PM. During an interview with the Administrator on at 12:17 PM, she stated that staff changed shifts between of them but the facility did not document it. The staff who exchanged shift just called and informed Staff G. The administrator stated that Staff C covered Staff F during Thursday's night shift. Then, the administrator added that all staff were in the building during the morning of . . . . . for receiving in-service regarding the hurricane season. Uncorrected Class III	{A 079}		
{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	{A 081}		

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{A 081}	Continued From page 60	{A 081}		

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.
(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

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{A 081}	Continued From page 61 trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that staff had at least 2 hours preservice orientation for two out of 10 sampled staff (Staff F and J). Findings included: Review of Staff F's personnel record showed that her hire date was on . There was no evidence that staff completed the 2-hours preservice orientation or that the staff completed core training. Review of Staff J's personnel record showed that her hire date was on . There was no	{A 081}		

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{A 081}	Continued From page 62 evidence that staff completed the 2-hours preservice orientation or that the staff completed core During an interview with the administrator on at 12:26 PM, she stated that Staff F and J completed all their training which were inside their personnel records. Uncorrected Class III	{A 081}		
A 125 SS=D	429.27(2) FS; 559A-36.013(3) FAC Fiscal - Surety Bonds 429.27 (2) A facility, or an owner, administrator, employee, or representative thereof, may not act as the guardian, trustee, or conservator for any resident of the assisted living facility or any of such resident's property. An owner, administrator, or staff member, or representative thereof, may not act as a competent resident's payee for social security, veteran's, or railroad benefits without the consent of the resident. Any facility whose owner, administrator, or staff, or representative thereof, serves as representative payee for any resident of the facility shall file a surety bond with the agency in an amount equal to twice the average monthly aggregate income or personal funds due to residents, or expendable for their account, which are received by a facility. Any facility whose owner, administrator, or staff, or a representative thereof, is granted power of attorney for any resident of the facility shall file a surety bond with the agency for each resident for whom such power of attorney is granted. The surety bond shall be in an amount equal to twice the average monthly income of the resident, plus the value of	A 125		

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A 125	Continued From page 63 any resident's property under the control of the attorney in fact. The bond shall be executed by the facility as principal and a licensed surety company. The bond shall be conditioned upon the faithful compliance of the facility with this section and shall run to the agency for the benefit of any resident who suffers a financial loss as a result of the misuse or misappropriation by a facility of funds held pursuant to this subsection. Any surety company that cancels or does not renew the bond of any licensee shall notify the agency in writing not less than 30 days in advance of such action, giving the reason for the cancellation or nonrenewal. Any facility owner, administrator, or staff, or representative thereof, who is granted power of attorney for any resident of the facility shall, on a monthly basis, be required to provide the resident a written statement of any transaction made on behalf of the resident pursuant to this subsection, and a copy of such statement given to the resident shall be retained in each resident's file and available for agency inspection. 59A-36.013 (3) SURETY BONDS. Pursuant to the requirements of section 429.27(2), F.S.: (a) For entities that own more than one facility in the state, one surety bond may be purchased to cover the needs of all residents served by the entities. (b) The following additional bonding requirements apply to facilities serving residents receiving : 1. If serving as representative payee for a resident receiving , the minimum bond proceeds must equal twice the value of the resident's monthly aggregate income, which must include any supplemental security income or	A 125		

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A 125	Continued From page 64 social security . . . . , income plus the . . . payments, including the personal needs allowance. 2. If holding a power of attorney for a resident receiving . . . , the minimum bond proceeds must equal twice the value of the resident's monthly aggregate income, which must include any supplemental security income or social security . . . . , income; the . . . payments, including the personal allowance; plus the value of any property belonging to a resident held at the facility. (c) Upon the annual issuance of a new bond or continuation bond, the facility must file a copy of the bond with the Agency Central Office. This Statute or Rule is not met as evidenced by: Based on record review and interview, the provider failed to have a surety bond with the minimum bond proceeds that equal twice the value of the resident's monthly aggregate income for three out of 17 sampled residents (#2, #7, and #10). Findings included: Record review revealed that the facility did not have proof of a surety bond with a minimum bond that equals twice the value of the resident's monthly aggregate income in the facility at the time of the survey. Record review revealed that the facility received a check from Social Security for the month of for Resident #2 in the amount of $583. Record review revealed that facility received a check from Social Security for the month of for Resident #7 in the amount of $426 and	A 125		

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A 125	Continued From page 65 $78. Record review revealed that the failty received a check from Social security for the month of for Resident #10 in the amount of $1324 . Review of facility records showed the facility collected $2411 for Residents #2, #7, and #10. The facility was required to have a surety bond for $4822. Review of facility records revealed the facility failed to have a surety bond. During an interiew on . . . . . at 9:07 AM with Staff B, he stated that the facility was the payee just for Residents #2 and #9. On further interview at 9:09 AM, the staff added that the facility did not have a surety bond with minimum requirements. Class III	A 125		
{A 152} SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no	{A 152}		

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{A 152}	Continued From page 66 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 have furniture in good working condition and to provide safe living environment. Finding included: Observation on at 6:41 AM showed that the room occupied by Resident #10, . . # , had a which drawers did not close and the closet did not have door. During an interview on . . . . . at 6:41 AM, Staff C stated that Resident #10 occupied . . # . During an interview on at 12:24 PM, the Administrator did not answer for possible	{A 152}		

Agency for Health Care Administration

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{A 152}	Continued From page 67 reasons that . . # had problems with the physical plan. Uncorrected Class III	{A 152}		