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
	AL11969287	A. BUILDING: _____ B. WING _____	06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALMER OAKS LLC	1525 PALMER AVE WINTER PARK, FL 32789

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Unannounced Complaint Investigation #2020009877 was conducted from . . . to 17, 2020. Palmer Oaks LLC had deficient practice found at the time of the visit.	A 000		
A 008 SS=D	429.26(.) FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (4) If possible, each resident shall have been examined by a licensed physician, a licensed physician assistant, or a licensed nurse practitioner within 60 days before admission to the facility. The signed and completed medical examination report shall be submitted to the owner or administrator of the facility who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission and continued stay in the facility. The medical examination report shall become a permanent part of the record of the resident at the facility and shall be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (5) Except as provided in s. 429.07, if a medical examination has not been completed within 60 days before the admission of the resident to the facility, a licensed physician, licensed physician assistant, or licensed nurse practitioner shall examine the resident and complete a medical examination form provided by the agency within 30 days following the admission to the facility to enable the facility owner or administrator to determine the appropriateness of the admission. The medical examination form shall become a	A 008		

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A 008	Continued From page 1	A 008		

permanent part of the record of the resident at the facility and shall be made available to the agency during inspection by the agency or upon request.
(6) Any resident accepted in a facility and placed by the department or the Department of Children and Families shall have been examined by medical personnel within 30 days before placement in the facility. The examination shall include an assessment of the appropriateness of placement in a facility. The findings of this examination shall be recorded on the examination form provided by the agency. The completed form shall accompany the resident and shall be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or [illegible] nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident providing it was completed within 90 days prior to admission to the facility. The applicable department shall provide to the facility administrator any information about the resident that would help the administrator meet his or her responsibilities under subsection (1). Further, department personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The

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A 008	Continued From page 2 applicable department shall advise and assist the facility administrator where the special needs of residents who are recipients of [illegible] require such assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a [illegible]-to-[illegible] medical examination completed by a health care provider as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 calendar days before the individual's admission to a facility pursuant to section 429.26(4), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations, 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living, 3. Any nursing or [illegible] services required by the individual, 4. Any special diet required by the individual, 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication, 6. Whether the individual has signs or symptoms of [illegible] or any other communicable [illegible], which are likely to be transmitted to other residents or staff, 7. A statement on the day of the examination that, in the opinion of the examining health care provider, the individual's needs can be met in an assisted living facility; and, 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care	A 008		

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A 008	Continued From page 3	A 008		

provider. The medical examination may be conducted by a health care provider licensed under chapter 458, 459 or 464, F.S.
(b) A medical examination completed after the resident's admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09170. Faxed or electronic copies of the completed form are acceptable. The form must be completed as instructed.
1. Items on the form that have been omitted by the health care provider during the examination may be obtained by the facility either orally or in writing from the health care provider.
2. Omitted information must be documented in the resident's record. Information received orally must include the name of the health care provider, the name of the facility staff recording the information, and the date the information was provided.
3. Electronic documentation may be used in place of completing the section on AHCA Form 1823 referencing Services Offered or Arranged by the Facility for the Resident. The electronic documentation must include all of the elements described in this section of AHCA Form 1823.
(c) Any information required by paragraph (a), that is not contained in the medical examination report conducted before the individual's admission to the facility must be obtained by the administrator using AHCA Form 1823 within 30 days after admission.
(d) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with

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A 008	Continued From page 4 either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of section 429.26, F.S. and this rule. (f) Any orders issued by the health care provider conducting the medical examination for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility may be attached to the health assessment. A health care provider may attach a DH Form 1896, Florida Form, for residents who do not wish to be administered in the case of or (g) A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 3 residents had properly completed Agency for Health Care Administration 1823 Health Assessments (#2 & #3).	A 008		

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A 008	Continued From page 5 Findings include: 1. Resident #2's file revealed an admission date of . . . . . Resident #2's 1823 was signed on . . . . . but failed to have a completed and signed section #3. 2. Resident #3's file revealed an admission date of . Resident #3's 1823 was signed on . . . . . but failed to have a completed and signed section #3. On at 12:39 PM, the administrator stated no one addressed the above with her before. Class III	A 008		
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	A 025		

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A 025	Continued From page 6 accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (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 record review and interviews, the facility placed 1 of 4 residents in imminent danger by failing to properly assess or make the required notification to a primary care physician, as the result of a resident found lying on the floor. The resident later . . . (#1). Findings:	A 025		

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A 025	Continued From page 7 On . . . . . at 10:15 AM, the assistant administrator stated she is responsible for the facility. The assistant administrator stated she was aware of the incident with Resident #1 on . . . . . . The assistant administrator stated staff found Resident #1 on the floor and they were not sure if she . This was an unwitnessed . The assistant administrator stated Resident #1 had a habit of sitting on the floor. The assistant administrator stated she did not become aware of the incident until staff notified her on . The administrator stated she called the hospice provider for Resident #1 on . The assistant administrator stated Resident #1's daughter and the hospice provider were not called on . When asked if the facility documented the resident's behavior of sitting on the floor and notifying Resident #1's primary care physician, she stated she was not sure. On at 12:35 PM, the administrator acknowledged she was aware of the situation with Resident #1 on . The administrator stated Resident #1 did not . but slid out of the chair onto the ground. When the details of the incident were reviewed with the administrator, she stated no one saw Resident #1 slide out of the chair. The administrator stated Resident #1 had a habit of looking at things while sitting down on the floor. The administrator stated she had not been called when the resident was found on the floor. The facility's operating procedure for included the following: call the administrator, evaluate the resident, investigate the circumstances, record circumstances, alert the primary care physician, immediate intervention, assessment, care plan and to monitor the resident. (photographic evidence obtained).	A 025		

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A 025	Continued From page 8 Resident #1's file reflected the resident had a diagnosis of . A review of resident #1's notes did not any documentation of resident #1 sitting on the floor. Resident #1's notes did not include document the on . Review of a note written by staff C, dated , reflected that staff C observed resident #1 looking at things on the floor. Resident #1 was then found on the floor and refused to get up. Staff C stated with the help of staff D, they placed resident #1 on a blanket and dragged her into her room, gave her a pillow and blanket and allowed her to sleep on the floor. Staff C documented she returned to the facility on at 8:20 AM and found resident #1 sitting in the recliner. Staff C stated she observed "redness" on her right cheek and . (photographic evidence obtained). A note written by staff D, dated , reflected that she observed resident #1 sitting on the floor. With the help of staff C, they placed resident #1 on a blanket and pulled her into her room and provided her a pillow and blanket so she could sleep on the floor. At 5 AM, she picked up resident #1 and placed her into a wheelchair. Staff C wrote she observed the assistant administrator arrived at 6:30 AM and looked at resident #1's . (photographic evidence obtained). Review an unsigned note in resident #1's chart, dated , reflected that resident #1 was complaining of left . (photographic evidence obtained). An unsigned note in resident #1's chart, dated , reflected that resident #1 did not sleep	A 025		

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A 025	Continued From page 9 and complained of "unbearable" left [illegible]. A note written by staff F on [illegible], reflected that staff F was told by staff E that resident #1 complained of [illegible] in her [illegible]. Staff F documented when she put resident #1 to bed, the resident told her she had [illegible] the night before. Staff F stated she did not observe any [illegible]. Staff F stated she texted the assistant administrator but did not get a response. (photographic evidence obtained). A note dated [illegible], reflected that staff C documented she arrived at the facility at 8:15 AM and staff F said resident #1 was complaining of [illegible] in her left [illegible]. The note reflected that resident #1 had refused breakfast and her morning medication. Staff C stated staff F told her to make sure she put the wheelchair in front of the bed so resident #1 did not slide off the bed. Staff C stated she contacted the assistant administrator and let her know about resident #1's [illegible]. On [illegible] at 1:30 PM, staff G was asked if she understood the facility's operating procedure for [illegible]. Staff G was unable to provide the facility required steps beyond stating, help the resident [illegible] up to their [illegible]. On [illegible] at 10:12 AM, staff C stated she worked on [illegible] and was aware of the incident with resident #1. Staff C stated resident #1 had been sitting at the dining room table. Staff C stated she was caring for other residents and found Resident #1 on the floor. She is not sure if she [illegible]. Staff C stated resident #1 liked to look at things on the floor and would sit down on the floor. Staff C stated she approached resident #1, but the resident refused her help in getting up.	A 025		

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A 025	Continued From page 10 Staff C stated she did not make an assessment and did not call the administrator or assistant administrator. Staff C stated when staff D arrived for the night shift on , she asked staff D to help lift resident #1. Staff C stated staff D said she could not because she (staff D) was in , . Staff C stated she suggested they, staff C and staff D roll her onto a blanket and drag her into her room for the night. Staff C stated they gave her a pillow and blanket so she could sleep on the floor. Staff C stated she returned to the facility on at 8:45 AM to complete paperwork and observed resident #1 sitting in the recliner. Staff C stated she noticed "redness" on upper right cheek and , . Staff C stated resident #1 stated she was in a , . Staff C said she did know the facility procedure, but she did not know resident #1 had . Resident #1's hospice notes reflected the hospice nurse arrived at the facility on at 1 PM. The hospice notes reflected that resident #1's extremities were bent, and she was yelling out in , . The hospice notes reflected that the hospice doctor ordered an , and , medication, Norco and . The , revealed a , . (photographic evidence obtained). On at 8:02 AM, resident #1's daughter stated she arrived at the facility on for her normal visit. Hospice Nurse stated she was greeted by staff C who stated resident #1 was not okay. The resident's daughter stated she went around to the outside doors into resident #1's room and observed resident #1 in a lot of , . The Resident's daughter stated she called the hospice nurse to come and help resident #1. Participant I stated when she learned of the diagnosis of a , , she stated the family made the decision to return resident #1 to the	A 025		

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A 025	Continued From page 11	A 025		

family's home. The resident's daughter stated they worked with the hospice provider to move her home on . . . . . The resident's daughter stated the resident #1 , , on .

On at 7:51 AM, the hospice nurse stated she was contacted by the facility on to provide hospice care for resident #1. The hospice nurse confirmed the written notes dated and provided by the hospice provider. The hospice nurse stated hospice care would remain in place on a 24-hour basis.

On at 7:52 AM, the assistant administrator stated she had been at the facility on at 6:30 AM and observed resident #1 with "puffy , ". The assistant administrator stated resident #1 always had puffy , . When asked if the facility had investigated the incident, she stated that she had talked to all the staff and did not think any action was warranted. The assistant administrator stated they have reminded staff regarding any hospice residents to always call hospice if they have a concern.

On at 7:56 AM, the Advanced Registered Nurse Practitioner (ARNP) stated she was the primary care physician/caregiver for resident #1. The ARNP stated the facility did not contact her until regarding the or injury to resident #1.

On . . . . . at 10 AM, staff F stated she reported to work on at 9 PM. She stated staff E told her resident #1 was in , . Staff F stated she talked to resident #1 who told her she had . . . the night before and was in , . Staff F stated she texted the assistant administrator and did not get a response from her. Staff F stated she observed resident #1

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A 025	Continued From page 12 patting her , when she was sleeping. Staff F stated she knows when a resident you are to call the administrator. On at 11:22 AM, the administrator stated they have texted all the staff to remind them to watch residents who are risk. The administrator was asked about the "wheel" in reference to resident #1's bed, which was referenced by staff. The administrator stated staff would place the wheelchair next to the bed so resident #1 could not get out of bed. When asked if resident #1 was a risk of getting out of bed, why did they not have the hospice provider secure a hospital bed and use half-rails if the doctor would order them. The administrator stated that was something they were working on. The Medical Examiner's report reflected that resident #1 , , on due to "complications of a ." Class I	A 025		
A 030 SS=J	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure	A 030		

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A 030	Continued From page 13 for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers. (e) Residents may not be required to perform any work in the facility without compensation.	A 030		

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	AL11969287	A. BUILDING: _____ B. WING _____	06/17/2020

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A 030	Continued From page 14 Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical . . . . . by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate	A 030		

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A 030	Continued From page 15 living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of	A 030		

Agency for Health Care Administration

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A 030	Continued From page 16 medications, assistance in making for health care services, the provision of or arrangement of transportation to health care , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The	A 030		

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A 030	Continued From page 17 notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder [redacted] Hotline operated by the Department of Children and Families, and, if applicable, [redacted], Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder [redacted] Hotline operated by the Department of Children and Families, and [redacted], Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated [redacted] or [redacted] under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for	A 030		

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A 030	Continued From page 18 the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the actions of the facility placed 1 of 4 residents in imminent danger, which included , by not providing an environment free of and neglect from staff (#1). Based on observation, record review and interviews, the facility failed to safe-guard 3 of 3 residents' well-being by failing to follow current control standards related to COVID-19 and Florida Governor's emergency orders DEM Order 20-06, dated , delineating minimum screening standards for persons entering identified residential facilities, and failed to establish as safe environment by requiring residents to wear coverings and practicing social distancing while outside of their rooms (#2, #3 & #4) . Findings: 1. On at 10:15 AM, the assistant administrator stated she is responsible for the facility. The assistant administrator stated she is aware of the incident with resident #1 on . The assistant administrator stated staff found resident #1 on the floor and they were not sure if she . The assistant administrator stated resident #1 had a habit of sitting on the floor. The assistant administrator stated she did not become aware of the incident until staff notified her on . The assistant administrator stated she called the hospice provider for resident #1 on , after she was notified by staff. The assistant administrator	A 030		

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A 030	Continued From page 19	A 030		

stated resident #1's daughter and hospice provider were not called on by staff. When asked if the facility documented the behavior of sitting on the floor and making notification to resident #1's primary care physician, she stated she was not sure. The assistant administrator stated staff C and staff D placed resident #1 on a blanket and dragged her into her room because she would not get up when asked. The assistant administrator stated they provided resident #1 with a blanket and pillow so she could sleep on the floor.

On at 12:35 PM, in an interview with the administrator, the administrator acknowledged she was aware of the situation with Resident #1 on . The administrator stated Resident #1 did not but slide out the chair onto the ground. When the agency reviewed the details, the administrator stated no one saw Resident #1 slid out of the chair. The administrator stated Resident #1 had a habit of looking at things on the floor and then sitting down on the floor. The administrator stated she had not been called by staff regarding the incident on .

Resident #1's file reflected that she had a diagnosis of . Resident #1's notes did not include any documentation of her sitting on the floor and did not include documentation of finding the resident on the floor on .

Review of a note written by staff C, dated , reflected that staff C observed resident #1 looking at things on the floor. Resident #1 was then found on the floor and refused to get up. Staff C stated with the help of staff D, they placed resident #1 on a blanket and dragged her into her room, gave her a pillow and

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A 030	Continued From page 20 blanket and allowed her to sleep on the floor. Staff C documented that she returned to the facility on [redacted] at 8:20 AM and found resident #1 sitting in the recliner. Staff C stated she observed "redness" on her right cheek and [redacted]. (photographic evidence obtained). Review of a note written by staff D, dated [redacted], reflected that she observed resident #1 sitting on the floor. With the help of staff C, they placed resident #1 on a blanket and pulled her into her room and provided her a pillow and blanket so she could sleep on the floor. At 5 AM, she picked up resident #1 and placed her into a wheelchair. Staff C wrote she observed the assistant administrator arrive at 6:30 AM and look at resident #1's [redacted]. (photographic evidence obtained). Review of an unsigned note in resident #1's chart, dated [redacted], reflected that resident #1 complained of [redacted] in her left [redacted]. (photographic evidence obtained). The chart did not contain any staff follow up with an administrator or primary care physician. Review of an unsigned note in resident #1's chart, dated [redacted]/202, reflected that resident #1 did not sleep and complained of "unbearable" [redacted]. (photographic evidence obtained). The chart did not contain any staff follow up with an administrator or primary care physician. Review of a note for resident #1, written by staff F on [redacted], reflected that staff F was told by staff E that resident #1 complained of [redacted] in her [redacted]. Staff F documented when she put resident #1 to bed, resident #1 told her she had [redacted] the night before. Staff F stated she did not observe any [redacted]. Staff F stated she texted the assistant administrator but did not get a	A 030		

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A 030	Continued From page 21 response. (photographic evidence obtained). Review of a note for resident #1, dated , Staff C documented she arrived at the facility at 8:15 AM and it was stated by staff F that resident #1 was complaining of in her left . The note reflected that resident #1 had refused breakfast and her morning medication. Staff C stated staff F told her to make sure she put the wheelchair in front of the bed so resident #1 did not slide off the bed. Staff C stated she contacted the assistant administrator and let her know about resident #1's . On , at 1:30 PM, staff G was asked if she understood the facility operating procedure for . Staff G was unable to provide of the facility required steps beyond stating, help the resident up to their . On at 9:10 PM, staff D stated she remembers the incident on . Staff D stated when she started the night shift around 7:45 PM, she observed resident #1 sitting on the floor. Staff D stated staff C asked her to help pick her up off the ground, but she declined because she was in . Staff D stated she helped staff C roll resident #1 onto a blanket and drag the blanket into resident #1's room. Staff D stated they provided resident #1 with a pillow and blanket so she could sleep on the floor. Staff D stated she checked on Resident #1 three times during the night. Staff D stated at 5 AM she lifted resident #1 onto a wheelchair so she could clean her. Staff D stated she then transferred her to the recliner. Staff D stated the assistant administrator arrived at the facility at 6:30 AM and she observed the assistant administrator look at the and of resident #1. When asked if she had been trained regarding she stated	A 030		

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A 030	Continued From page 22 no, she was not aware. On . . . . . at 10:12 AM, staff C stated she worked on and was aware of the incident with resident #1. Resident #1 refused her help in getting up. Staff C stated she did not make an assessment and did not call the administrator or assistant administrator. Staff C stated when staff D arrived to work for the night shift on , she asked staff D to help lift resident #1. Staff C stated staff D stated she could not because she (Staff D) was in , . Staff C stated she suggested they roll her onto a blanket and drag her into her room for the night. Staff C stated they gave her a pillow and blanket so she could sleep on the floor. Staff C stated she returned to the facility on . . . . . at 8:45 AM to complete paperwork and observed resident #1 sitting in the recliner. Staff C stated she noticed, "redness" on her upper right cheek and , . Staff C stated resident #1 stated she was in a , . Staff C stated she did know the facility's procedure, but she did not know resident #1 had . Review of hospice notes for resident #1 reflected that the hospice nurse arrived at the facility on at 1 PM. The hospice notes reflected that resident #1's extremities were bent, and she was yelling in , . The hospice notes reflected that the hospice doctor ordered an , and , medication, Norco and . The , report noted a , ... (photographic evidence obtained). The Medical Examiners Report reflected that resident #1 , ... , on . . . . . due to "complications of a , ". On at 7:51 AM, the hospice nurse	A 030		

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A 030	Continued From page 23	A 030		

stated she was contacted by the facility on to provide hospice care for resident #1. The hospice nurse confirmed the written notes, dated and provided by the hospice provider. The hospice nurse stated hospice care would remain in place on a 24-hour basis.

On at 7:52 AM, the assistant administrator stated that she had talked to all the staff and did not think any action was warranted. The assistant administrator stated they have reminded staff regarding any hospice residents to always call hospice if they have a concern.

On at 7:56 AM, the Advanced Nurse Practitioner (ARNP) stated she was the primary care physician/caregiver for resident #1. The ARNP stated the facility did not contact her until , four days after the resident was found on the floor, regarding the or injury to resident #1.

On at 8:02 AM, the resident's daughter stated she arrived at the facility on for her normal visit. Participant I stated she was greeted by staff C who stated resident #1 was not okay. Resident #1's daughter stated she observed resident #1 in a lot of , . The resident's daughter stated she called participant H to come and help resident #1. Participant 1 stated when she learned of the diagnosis of a , , participant I stated the family made the decision to return resident #1 to the family's home. The resident's daughter stated they worked with the hospice provider to move her home on . The resident's daughter stated resident #1 , , on .

On at 10 AM, staff F stated she reported to work on at 9 PM. Staff F

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A 030	Continued From page 24 stated Staff E told her Resident #1 was in . Staff F stated resident #1 told her she had the night before and was in . Staff F stated she texted the assistant administrator and did not get a response from her. Staff F stated she observed resident #1 patting her when she was sleeping. Staff F confirmed she had provided documentation in resident #1's chart. Staff F stated she knows when a resident you are to call the administrator. On at 11:22 AM, the administrator stated they have texted all the staff to remind them to watch residents who are risk. The administrator was asked about the "wheel" in reference to resident #1's bed, referenced by staff. The administrator stated they would place the wheelchair next to the bed so resident #1 could not get out of bed. When asked if resident #1 was a risk of getting out of bed, why did they not have the hospice provider secure a hospital bed and use the half-rails if the doctor ordered them, the administrator stated that was something they were working on. On at 10:15 AM, the assistant administrator was asked about the family members for resident #1 being able to visit the facility. The assistant administrator stated the family members would go to the yard and resident #1 would open the French doors so they could visit. 2. 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.	A 030		

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A 030	Continued From page 25 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 assisted living facilities that all staff or other individuals admitted to a 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 . Based on a record review of the Center for Control and Prevention (CDC), considerations when preparing for COVID-19 in	A 030		

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A 030	Continued From page 26 Assisted Living Facility, it is recommended assisted living facilities take the following actions to protect residents and staff: encourage the residents to wear coverings and practice social distancing when outside of their apartments, staff to wear mask, provide access to -based sanitizer, test residents and staff for temperatures and designate one central point of entrance. On at 10:05 AM, the following was observed: the facility failed to screen the agency surveyor when entering the building regarding the complaint, and residents #2 and #3 sat at the dining room table talking, with less than two of distance and neither one wearing a mask or covering. On at 10:15 AM, the assistant administrator stated the facility has a policy regarding COVID-19 and visitors; they do not allow non-medical personnel, family members; staff and everyone must sign in. It was then explained to her that staff failed to screen the agency's representative. She stated she is not sure why they did not do it. The assistant administrator provided the sign in sheets which listed the name, date and time, but no questions about prior exposure or temperature. On at 10:35 AM, when asked why she is not wearing a mask resident #2 and stated, "I don't know". Review of the facility's control policy highlights were: 1- sick employees must stay home, 2- make notification if you have a , problem, 3-wash your , 4-cover your and , 5-environmental cleaning, 6-limit visitors to third-party providers, 7-provide	A 030		

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	AL11969287	A. BUILDING: _____ B. WING _____	06/17/2020

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A 030	Continued From page 27 alternate methods for residents to visit loved ones. On at 12:24 PM, the administrator stated they have an control policy which restricts visitors, and everyone gets screened when they enter, including third party providers and staff. The administrator stated she is not certain why the staff neglected to screen the agency staff. The administrator stated they allowed the family of resident #1 to go to the rear of the facility since resident #1 was on hospice and had doors which opened to the outside. On at 10 AM, resident #4 was asleep by the front door without a mask. Residents #2 and #3, visiting in Resident #2's room, were both within 2 of one another and neither wore a mask or covering. On at 11:25 AM, resident #3 stated we don't have to wear the mask. On at 11:22 AM, the administrator stated the residents have and will not cooperate. The administrator stated they allow all the residents to eat together. Review of resident #2's 1823 health assessment, the 1823 form did not show resident #2 with a diagnosis of . Class I	A 030		
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	A 081		

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A 081	Continued From page 28 living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in [illegible] control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its [illegible] control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to [illegible] borne [illegible], may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents.	A 081		

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A 081	Continued From page 29 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , ... The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 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:	A 081		

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A 081	Continued From page 30 Based on record reviews and interviews, the facility failed to ensure 3 of 3 staff had documentation of having completed the required pre-service orientation (C, F & K). Findings: 1. Reeview of staff C's employee file reflected a date of hire as . . . . . . The file did not contain documentation that staff C completed the required pre-service orientation. 2. Review of staff F's employee file reflected a date of hire as . The file did not contain documentation that staff F completed the required pre-service orientation. 3. Review of staff K's employee file reflected a adate of hire as . . . . . The file did not contain documentation that staff F completed the required pre-service orientation. On . . . . . at 11:22 AM, the administrator stated she did not think this was correct because the staff were hired in 2017. Class III	A 081		
CZ814 SS=C	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12(2) Care Provider Background Screening Clearinghouse.- (b) Until such time as the , are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national	CZ814		

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CZ814	Continued From page 31 screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic , submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility placed residents at-risk by failing to ensure 1 of 3 staff had an updated level 2 background screening, as required, based on a 90-day gap at the time of hiring (F). Findings: Review of staff F's employee file reflected a date of hire as . Staff F's file contained a background screening date as . A review of the facilitiy's background screening roster reflected thast staff F's date of hire was and background screen date was . On at 10 AM, staff F stated she did not	CZ814		

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CZ814	Continued From page 32 work at any facility or program after getting her level 2 background screening which would require a level 2 background screen. On [redacted] at 11:22 AM, the administrator did not challenge the findings as presented. Unclassified	CZ814		
CZ821 SS=C	59A-35.110 FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under chapter 408, part II, F.S., or authorizing statutes for the provider type as specified in section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections; and, (f) Approval of revisions to emergency management plans. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes:	CZ821		

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CZ821	Continued From page 33 Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and availiable at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 2. Assisted living facilities: a. Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 days after the occurrence of the incident as required in section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and availiable at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. b. Liability claim reports required pursuant to section 429.23(5), F.S., and rule 58A-5.0242, F.A.C. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL,	CZ821		

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CZ821	Continued From page 34 , , which is hereby incorporated by reference and availiable at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , which is hereby incorporated by reference and availiable at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to file an Adverse Incident Report (AIRS) for an incident which required a resident (#1) to be transported to a higher level of care; the facility failed to file an AIRS report which	CZ821		

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CZ821	Continued From page 35 accurately documented the incident and failure to make the required notification to the state-wide ..... system. Findings: Review of notes for resident #1 reflected the following entry on : Resident #1 had erratic behavior, exit- seeking, broke a front window and cut , screaming and yelling to return home; 911 was called and resident #1 was transported to a local hospital for a higher level of care. On ..... at 12:24 PM, the administrator acknowledged the facility had failed to file an AIRS report related to the incident on ....., involving resident #1 being taken to a higher level of care. The administrator stated she faxed an AIRS report to the Agency for Health Care Administration (AHCA) AIRS system on related to resident found on the floor on ..... Review of the AIRS system reflected that resident #1 was found on the floor on . The AIRS report reflected the following: the report was filed with the AIRS system on . It read tht resident #1 complained of on at 7:50 PM; staff E observed resident #1's and did not observe any marks or on , staff C contacted the assistant administrator who called the third-party hospice provider for resident #1. The AIRS system report, filed on related to resident #1, failed to contain the following items: 1. On at 10:12 AM, in an interview with staff C, Staff C stated she was working on	CZ821		

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CZ821	Continued From page 36 . . . . . and is aware of the situation with resident #1. Staff C stated resident #1 had been sitting at the dining room table. Staff C stated she was caring for other residents and found resident #1 on the floor, she is not sure if she . Staff C stated resident #1 liked to look at things on the floor and would sit down on the floor. Staff C stated she approached resident #1 but resident #1 refused her help in getting up. Staff C stated she did not make an assessment and did not call the administrator or assistant administrator. Staff C stated when staff D arrived to work for the night shift on . . . . . , she asked staff D to help lift resident #1. Staff C stated staff D stated she could not because she (Staff D) was in . Staff C stated she suggested they (staff C & D) roll her onto a blanket and drag her into her room for the night. Staff C stated they gave her a pillow and blanket so she could sleep on the floor. Staff C stated she returned to the facility on at 8:45 AM to complete paperwork and observed resident #1 sitting on the recliner. Staff C stated she noticed, "redness" on upper right cheek and . Staff C stated Resident #1 stated she was in a . Staff C when asked stated she did know the facility procedure, but she did not know resident #1 had ." 2. On at 9:10 PM, staff D stated she had written a note. Staff D stated she remembers the incident on . Staff D stated when she started the night shift around 7:45 PM, she observed resident #1 sitting on the floor. Staff D stated staff C asked her to help pick her up off the ground, but she declined because she was in . Staff D stated she helped staff C roll resident #1 onto a blanket and drag the blanket into resident #1's room. Staff D stated they provided resident #1 with a pillow and blanket so she could sleep on the floor. Staff D stated she checked on resident #1 three times during the	CZ821		

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CZ821	Continued From page 37 night. Staff D stated at 5 AM, she lifted resident #1 onto a wheelchair so she could clean her. Staff D stated she then transferred her to the recliner. Staff D stated the assistant administrator arrived at the facility at 6:30 AM and she observed the assistant administrator look at the , and of resident #1. When asked if she had been trained regarding and knew the facility procedure, staff D stated she was not aware. 3. On , review of hospice notes for resident #1 reflected that participant H arrived at the facility on at 1 PM. The hospice notes reflected that resident #1's extremities were bent and she was yelling in , . The hospice notes reflected that the hospice doctor ordered an , and , medication, Norco and . The , report showed a , . (photographic evidence obtained). Unclassified	CZ821		