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 |
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| | AL11968482 | A. BUILDING: _____ B. WING _____ | 10/27/2020 |

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| LOVING ANGELS ASSISTED LIVING LLC | 9 RAMBLE WAY PALM COAST, FL 32164 |

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| A 000 | Initial Comments<br><br>An unannounced biennial licensure survey, and [redacted] Control Focused survey was conducted at Loving Angels Assisted Living from [redacted] to [redacted]. Deficiencies were found at the time of the visit. | A 000 | | |
| A 008 | 429.26( ) FS; 59A-36.006(2) FAC Admissions - Health Assessment<br><br>429.26<br>(5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must 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 to or continued residency in the facility. The medical examination form may only be used to record the practitioner's direct observation of the patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form, reflecting the resident's condition on the date the examination is performed, becomes a permanent part of the facility's record of the resident and must be made | A 008 | | |

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| A 008 | Continued From page 1<br>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.<br>(6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and must 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 provided that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or her responsibilities under subsection (1). Further, Department of | A 008 | | |

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| A 008 | Continued From page 2<br><br>Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of [illegible] require such assistance.<br><br>59A-36.006<br>(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.<br>(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:<br>1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations,<br>2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living,<br>3. Any nursing or [illegible] services required by the individual,<br>4. Any special diet required by the individual,<br>5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication,<br>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,<br>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 | A 008 | | |

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| A 008 | Continued From page 3<br><br>assisted living facility; and,<br>8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care provider. The medical examination may be conducted by a health care provider licensed under chapter 458, 459 or 464, F.S.<br>(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, [illegible], 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.<br>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.<br>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.<br>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.<br>(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 | A 008 | | |

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| A 008 | Continued From page 4<br><br>days after admission.<br>(d) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b).<br>(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.<br>(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<br>Form, for residents who do not wish<br>to be administered<br>in the case of or<br>(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.<br><br>This Statute or Rule is not met as evidenced by: | A 008 | | |

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| A 008 | Continued From page 5<br><br>Based on observation, review of resident records and interview with staff, the facility failed to maintain complete and accurate resident health assessments (AHCA form 1823s) for 2 of 3 residents whose records were reviewed (Residents 2 and 6).<br><br>The findings include:<br><br>1. An observation of Resident 6 was conducted at 11:26 am on . He was with Employee A, Caregiver, who was assisting him with the self-administration of his medication. Employee A assisted Resident 6 with the set up on his . When handed the , , Resident 6 dialed the pen to 30 units. Without assistance, Resident 6 injected the into the left side of his abdomen.<br><br>Record review for Resident 6 revealed an AHCA form 1823 (Resident Health Assessment) dated . Resident 6 was noted as , requiring frequent reminders. He required assistance with activities of daily living and daily oversight for his wellbeing. Section C. of the assessment stated he required 24 hour nursing care and that his needs could not be met in an assisted living facility. Page 4. noted Resident 6 needed to have his medications administered for him. Page 5. of the assessment, which is intended to be completed by the Administrator to list the services provided by the facility, was missing altogether. Further review of the record confirmed Resident 6 had a diagnosis of . . . . . Photographic evidence was obtained.<br><br>An interview was conducted with the Owner at | A 008 | | |

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| A 008 | Continued From page 6<br><br>1:54 pm on [redacted]. She reviewed Resident 6's health assessment and stated maybe she took out page 5. to have Employee D sign it. She acknowledged the Administrator was supposed to sign it. She also acknowledged the assessment indicated Resident 6 required medication administration but was observed to administer his own with only some assistance from Employee A, and that he was noted to need 24-hour nursing services and was not appropriate for an assisted living facility.<br><br>2. Record review for Resident 2 revealed an AHCA 1823 dated [redacted]. The 5-page form was incomplete, as it only contained pages 1 and 4. The form omitted the sections asking the following: Her elopement risk status; the level of assistance she needed with activities of daily living; dietary instructions; communicable status; [redacted] status; whether or not she presented a danger to herself or others; whether or not she required 24-hour nursing or [redacted] care; whether or not her needs could be met in an assisted living facility; her ability to perform self-care and independent living tasks; and, her need for general oversight. The last page, which is intended to be completed by the Administrator to list services the facility would provide this resident, was missing.<br><br>An interview was conducted with Employee D, Caregiver, at 2:15 pm. She reviewed the assessment and confirmed the missing pages and required information.<br><br>Class III | A 008 | | |

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| A 032 | Continued From page 7 | A 032 | | |
| A 032 | 59A-36.007(8) FAC Resident Care - Elopement Standards<br><br>59A-36.007<br>(8) ELOPEMENT STANDARDS.<br>(a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days.<br>1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times.<br>2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the | A 032 | | |

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| A 032 | Continued From page 8<br><br>resident's representative.<br>(b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for:<br>1. An immediate search of the facility and premises,<br>2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities,<br>3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and,<br>4. The continued care of all residents within the facility in the event of an elopement.<br>(c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to sections 429.41(1)(a)3. and 429.41(1)(l), F.S.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interviews the facility failed conduct elopement drills with staff twice per year for two of two years reviewed.<br><br>The findings include:<br><br>A review of the elopement drill book provided by Employee D on . . . . . at 2:25 PM revealed the most recent elopement drill was conducted on . . . . . and . . . . . Photographic evidence obtained.<br><br>During an interview with Employee B on | A 032 | | |

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| A 032 | Continued From page 9<br><br>at 2:09 PM she was asked if she had participated in an elopement drill and she stated she had not. Records indicated Employee B was hired .<br><br>During an interview with Employee D on at 2:40 PM, she confirmed the most recent elopement drill in the elopement book was on . Employee D was asked when she last participated in an elopement drill and she stated could not recall and that they were due for one.<br><br>During an interview with the Owner of the facility on at 4:11 PM she was notified the elopement drill book was not up to date. She did not have any other evidence showing the facility was conducting elopement drills to provide.<br><br>Class III | A 032 | | |
| A 076 | 59A-36.009 FAC<br>( )<br><br>(1) POLICIES AND PROCEDURES.<br>(a) Each assisted living facility must have written policies and procedures that explain its implementation of state laws and rules relative to ( ). An assisted living facility may not require execution of a as a condition of admission or treatment. The assisted living facility must provide the following to each resident, or resident's representative, at the time of admission:<br>1. Form SCHS- , "Health Care Advance Directives - The Patient's Right to Decide," , , or with a copy of some other substantially similar document, which incorporates information | A 076 | | |

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| A 076 | Continued From page 10<br>regarding advance directives included in chapter 765, F.S. Form SCHS- is available from the Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 34, Tallahassee, FL 32308 or the agency's website at: http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/HC_Advance_Directives/docs/adv_dir.pdf; and,<br>2. DH Form 1896, Florida Form, , 2004, which is hereby incorporated by reference. This form may be obtained by calling the Department of Health's toll free number 1(800)226-1911, extension 2780 or online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04005.<br>(b) There must be documentation in the resident's record indicating whether a DH Form 1896 has been executed. If a DH Form 1896 has been executed, a yellow copy of that document must be made a part of the resident's record. If the assisted living facility does not receive a copy of a resident's executed DH Form 1896, the assisted living facility must document in the resident's record that it has requested a copy.<br>(c) The executed DH Form 1896 must be readily available to medical staff in the event of an emergency.<br>(2) LICENSE REVOCATION. An assisted living facility's license is subject to revocation pursuant to section 408.815, F.S., if, as a condition of treatment or admission, the facility requires an individual to execute or waive DH Form 1896.<br>(3) PROCEDURES. Pursuant to section 429.255, F.S., an assisted living facility must honor a properly executed DH Form 1896 as follows:<br>(a) In the event a resident experiences or , staff trained in , | A 076 | | |

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| A 076 | Continued From page 11<br>( ) or a health care provider present in the facility, may withhold ( and ).<br>(b) In the event a resident is receiving hospice services and experiences or , facility staff must immediately contact hospice staff. The hospice procedures take precedence over those of the assisted living facility.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, review of resident records and interview with staff, the facility failed to obtain ( 's), for 1 of 2 residents reviewed. (Resident 3) out of a total of 6 residents in the sample.<br><br>The findings include:<br><br>Record review for Resident 3 revealed he was admitted to the facility on and signed a paper on that he had a . (Photographic evidence obtained.) Further record review for Resident 3 found no evidence of a in his resident file.<br><br>Caregiver A was asked for the for Resident 3 on at 12:18 PM. She was observed going into the garage. When she returned from the garage at 12:20 PM she was asked if the facility had a book. She stated she did not have anything to provide.<br><br>On at 1:00 PM the Owner was asked for the info for Resident 3. She stated he did not have anything and that he was full code. She was shown the paper the resident's POA signed stating the resident had a . She | A 076 | | |

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| A 076 | Continued From page 12<br><br>stated she spoke to the POA for Resident 3. She stated she did not know when and the POA did not have any paperwork provide.<br><br>Class III | A 076 | | |
| A 077 | 429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators<br><br>429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements.<br><br>429.52<br>(4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule.<br>(5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years.<br><br>59A-36.010<br>(1) ADMINISTRATORS. Every facility must be | A 077 | | |

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| A 077 | Continued From page 13<br>under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter.<br>(a) An administrator must:<br>1. Be at least [illegible];<br>2. If employed on or after [illegible], have, at a minimum, a high school diploma or G.E.D.;<br>3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.;<br>4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to [illegible], are not required to take the competency test unless specified elsewhere in this rule; and,<br>5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C.<br>Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department.<br>(b) In the event of extenuating circumstances, such as the [illegible] of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: | A 077 | | |

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| A 077 | Continued From page 14<br><br>1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and,<br>2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility.<br>(c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities.<br>(d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility.<br>(e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: | A 077 | | |

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| A 077 | Continued From page 15<br><br>http://www.flrules.org/Gateway/reference.asp?No=Ref-09393.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on interviews observations and interviews with staff and residents, the Administrator failed to supervise and hold responsibility for the operation and maintenance of the facility including the management of all staff and the provision of care to residents. The facility failed to ensure operational matters were conducted by qualified individuals in the Administrator's absence. This has the potential to affect all 6 residents of the facility.<br><br>The findings include:<br><br>On entrance to the facility at 9:45 am on [redacted], Employee A, Caregiver, was asked to notify the Administrator of the survey commencement. Instead, Employee A notified the Owner. At this time, the Owner was asked to notify the Administrator of the survey's commencement.<br><br>Resident 6 was interviewed on [redacted] at 9:58 am. He stated he would go to the Owner if he had any concerns but the Owner was hardly ever at the facility. Resident 6 stated he never saw the facility Administrator. He explained it was Employee A who was here everyday, she comes early in the morning and leaves about 7:00 pm at night. There was only one staff person in the facility during the day.<br><br>An interview was conducted with Resident 2 at | A 077 | | |

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| A 077 | Continued From page 16<br><br>10:00 am on . . . . . . . She was asked if she ever saw the Administrator in the facility. She replied not that much. She only sees the Owner. The Administrator comes every 3 weeks for 1/ 2 hour to an hour. The Owner was the one who was here and she was who the residents contacted for all of their needs. When asked who she would report a problem to if she had one, she replied the Owner. If unable to rectify the problem, the Owner would then call the Administrator to come and fix it.<br><br>The facility Owner arrived at 10:15 am on . . . . . , but the Administrator still had not arrived. A telephone interview was conducted with the Administrator at approximately 11:00 am on . He stated he would come to the facility to assist with the licensure survey.<br><br>An interview was conducted with Employee A, Caregiver, at 10:40 am on . . . . . . She stated when the Administrator did arrive in the building, it was usually from 7:00 pm to 8:00. She would not specify what days or how frequently he came, or what involvement he had in the day to day operations of the facility.<br><br>An interview was conducted with Resident 4 at 12:40 pm on . He was asked who he would report a problem to, should he have one. He replied, the Owner. She was here weekly. He stated the Administrator was Employee D (a Caregiver). She was here 5 days a week. Resident 4 stated the Administrator of record came to the facility once a week whenever they needed something fixed. He was not here very often. | A 077 | | |

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| A 077 | Continued From page 17<br><br>At 1:00 pm on [redacted], Employee D, Caregiver, arrived. She introduced herself and stated she had been working on taking over the Administrator's duties for approximately 2 months or so. She had not taken the core training test yet.<br><br>At approximately 2:00 pm on [redacted], the Owner was asked where the Administrator was, as he had not yet arrived. She explained he was working. She stated he worked full time elsewhere.<br><br>Throughout the survey from 10:15 am to 4:30 pm on [redacted], the Owner assisted with obtaining needed and missing information for the survey team, departing the facility in her car several times to look for needed information. She was never heard consulting with the Administrator via telephone to ask for the location for missing documents.<br><br>Review of the Final Order for case number 2015010450 revealed the Owner was listed in the terms of the settlement agreement. She was not to have ownership interest in the facility, be a "controlling interest" in the facility, or have control, directly or indirectly, in the day to day operation of the facility.<br><br>In a final interview with the Owner at 4:30 pm on [redacted], she was asked who was really providing oversight to the facility, given she had been the only one assisting the survey team | A 077 | | |

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| A 077 | Continued From page 18<br><br>during the inspection. She was asked directly if assumed the responsibilities of the Administrator of this facility. She stated she was in the process of replacing her Administrator with Employee D, who had been core trained. She was hopeful Employee D would pass her test. The Owner was asked directly if she was the person actually providing administrative oversight to this facility and she nodded her yes.<br><br>By the time the team exited the facility at 4:30 pm on , the Administrator had not arrived.<br><br>2. Record review of the Administrator's employee file revealed he was hired on . Because no evidence of core training was found in the record, the owner was asked to produce evidence he maintained his core certification. She left the facility around 2:30 PM on and returned about 45 minutes later with the certification number of 171239970 issued .<br><br>Further record review of the employee file for the Administrator found the only evidence of training since was a 6 hour medication training on and a 1 hour first aid training on .<br><br>In an interview with Employee A at 10:40 am on , she stated she worked Mondays, Wednesdays and Fridays from 8:00 am - 8:00 pm. Employee D worked the same shift on Tuesdays, Thursdays and Saturdays. Employee B worked the overnight shifts. Record review for Employee A (hired ) found her first aid training expired on . | A 077 | | |

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| A 077 | Continued From page 19<br><br>The findings were confirmed during an interview with Employee A on at 10:50 AM. She stated she did not have a current First Aid card. She confirmed she worked alone in the facility during the 8:00 AM to 8:00 PM shift.<br><br>Review of the facility schedules for and found there were 2 sets of staff initials were written in each day; one set of initials on the top and one set on the bottom of each calendar day. There were no hours specified on the schedule for any of the staff initials. The schedule indicated one to two staff member were scheduled to work per day. The initials were for direct care staff and the Administrator's initials were not present. Photographic evidence was obtained.<br><br>Based on a census of residents, the minimum staffing hours required for is 212 hours per week. of the scheduled hours for to and for to found only 168 staffing hours were provided weekly for the 6 residents.<br><br>An interview was conducted with the Owner at 4:13 pm on because the facility Administrator was not present during the survey. She reviewed the schedules and acknowledged the staffing hours 44 hours short of the minimum weekly requirement for the current census of 6.<br><br>Class III | A 077 | | |
| A 079 | 59A-36.010(3) FAC Staffing Standards - Levels | A 079 | | |

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| A 079 | Continued From page 20<br><br>(3) STAFFING STANDARDS.<br>(a) Minimum staffing:<br>1. Facilities must maintain the following minimum staff hours per week:<br><br>Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week<br>0-5 168<br>6-15 212<br>16-25 253<br>26-35 294<br>36-45 335<br>46-55 375<br>56-65 416<br>66-75 457<br>76-85 498<br>86-95 539<br><br>For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week.<br>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.<br>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.<br>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. | A 079 | | |

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| A 079 | Continued From page 21<br>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.<br>a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement.<br>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 .<br>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.<br>7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement.<br>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.<br>9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. | A 079 | | |

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| A 079 | Continued From page 22<br>(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.<br>(c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives.<br>(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.<br>1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time | A 079 | | |

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| A 079 | Continued From page 23<br><br>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.<br>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.<br>(e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios.<br>(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.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observations, interviews with residents and staff and review of employee schedules, the facility failed to ensure sufficient staffing per week for the census of 6 residents.<br><br>The findings include:<br><br>On arrival to the facility on . . . . . at 9:45 am Employee A, Caregiver, was present and working alone. During the tour of the facility at 10:00 am on , it was determined there were 6 | A 079 | | |

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| A 079 | Continued From page 24<br><br>residents residing in the home. Resident 1 was observed in her bed and did not respond to the surveyor's presence or greetings. Employee A explained at this time that Resident 1 was on hospice services and required total care.<br><br>During and interview with Resident 6 on [redacted] at 9:58 am, he stated Employee A, caregiver, was here every day. She came in early in the morning and left about 7:00 at night. There was only one staff person at a time in the facility during the day.<br><br>In an interview with Employee A at 10:40 am on [redacted], she stated she worked Mondays, Wednesdays and Fridays from 8:00 am - 8:00 pm. Employee D worked the same shift on Tuesdays, Thursdays and Saturdays. Employee B worked the overnight shifts. Review of the schedules at this time found the [redacted] schedule was not in the binder. Employee A was asked to locate it, but was unable to do so.<br><br>Review of the facility schedules for [redacted] and [redacted] found there were 2 sets of staff initials were written in each day; one set of initials on the top and one set on the bottom of each calendar day. There were no hours specified on the schedule for any of the staff initials. The [redacted] schedule read as follows:<br><br>Sundays: Employee D and Employee B's initials were present with no specific times.<br>Mondays: Employee A's initials were present with no specific times.<br>Tuesdays: Employee D and Employee B's initials | A 079 | | |

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| A 079 | Continued From page 25<br>were present with no specific times.<br>Wednesdays: Employee A and Employee A's initials were present with no specific times.<br>Thursdays: on , only Employee D was marked, with no specific times. All other Thursdays noted Employee D and Employee B's initials with no specific times.<br>Fridays: Employee A and Employee E's initials were present with no specific times.<br>Saturday: Employee D and Employee B's initials were present with no specific times.<br><br>Review of the schedules for revealed the following:<br><br>Sundays: Employee D and Employee B's initials were present with no specific times.<br>Mondays: Employee A's initials were present with no specific times.<br>Tuesdays: Employee D and Employee B's initials were present with no specific times.<br>Wednesdays: Employee A's initials were present with no specific times.<br>Thursdays: Employee D and Employee B's initials were present with no specific times.<br>Fridays: Employee A and Employee E's initials were present with no specific times.<br>Saturday: Employee D and Employee B's initials were present with no specific times.<br><br>Photographic evidence was obtained.<br><br>Based on a census of residents, the minimum staffing hours required for is 212 hours per week. of the scheduled hours for to and for to found only | A 079 | | |

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| A 079 | Continued From page 26<br>168 staffing hours were provided weekly for the 6 residents.<br><br>An interview was conducted with the Owner at 4:13 pm on because the facility Administrator was not present during the survey. She reviewed the schedules and acknowledged the staffing hours 44 hours short of the minimum weekly requirement for the current census of 6.<br><br>Class III | A 079 | | |
| A 080 | 429.52( ) FS; 59A-36.011(1) FAC Training - Core & Competency Test<br><br>429.52<br>(2) Administrators and other assisted living facility staff must meet minimum training and education requirements established by the agency by rule. This training and education is intended to assist facilities to appropriately respond to the needs of residents, to maintain resident care and facility standards, and to meet licensure requirements.<br>(3) The agency, in conjunction with providers, shall develop core training requirements for administrators consisting of core training learning objectives, a competency test, and a minimum required score to indicate successful passage of the core competency test. The required core competency test must cover at least the following topics:<br>(a) State law and rules relating to assisted living facilities.<br>(b) Resident rights and identifying and reporting , neglect, and , .<br>(c) Special needs of elderly persons, persons with | A 080 | | |

Agency for Health Care Administration

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| A 080 | Continued From page 27<br>mental illness, and persons with . . . . , . . . . and how to meet those needs.<br>(d) Nutrition and food service, including acceptable sanitation practices for preparing, storing, and serving food.<br>(e) Medication management, recordkeeping, and proper techniques for assisting residents with self-administered medication.<br>(f) Fire safety requirements, including fire evacuation drill procedures and other emergency procedures.<br>(g) Care of persons with 's and related . . . . . .<br><br>59A-36.011<br>(1) ASSISTED LIVING FACILITY CORE TRAINING REQUIREMENTS AND COMPETENCY TEST.<br>(a) The assisted living facility core training requirements established by the department pursuant to section 429.52, F.S., shall consist of a minimum of 26 hours of training plus a competency test.<br>(b) Administrators and managers must successfully complete the assisted living facility core training requirements within 3 months from the date of becoming a facility administrator or manager. Successful completion of the core training requirements includes passing the competency test. The minimum passing score for the competency test is 75%. Administrators who have attended core training prior to . , . . , and managers who attended the core training program prior to , . . , shall not be required to take the competency test. Administrators licensed as nursing home administrators in accordance with chapter 468, part II, F.S., are exempt from this requirement.<br>(c) Administrators and managers shall participate | A 080 | | |

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| A 080 | Continued From page 28<br><br>in 12 hours of continuing education in topics related to assisted living every 2 years.<br>(d) A newly hired administrator or manager who has successfully completed the assisted living facility core training and continuing education requirements, shall not be required to retake the core training. An administrator or manager who has successfully completed the core training but has not maintained the continuing education requirements will be considered a new administrator or manager for the purposes of the core training requirements and must:<br>1. Retake the assisted living facility core training; and,<br>2. Retake and pass the competency test.<br>(e) The fees for the competency test shall not exceed $200.00. The payment for the competency test fee shall be remitted to the entity administering the test. A new fee is due each time the test is taken.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on employee record review and an interview with the owner, the facility failed to ensure the Administrator participated in 12 hours of continuing education in topics related to assisted living every 2 years.<br><br>The findings include:<br><br>Record review of the employee file for the Administrator revealed he was hired as the Administrator of the facility on . Further record review of his employee file found no evidence of Core training. The owner was notified that the Administrators employee file was missing his core training. The owner left the facility around 2:30 PM and returned on at 3:13 PM. | A 080 | | |

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| A 080 | Continued From page 29<br><br>She provided a core certificate with the certification number of 171239970 issues .<br><br>Further record review of the employee file for the Administrator found the only evidence of training since was a 6 hour medication training on and a 1 hour first aid training on .<br><br>During further interview with the owner of the facility on at 3:15 AM, she stated the only training she had for the Administrator was in the two files she had provided.<br><br>A telephone conversation was held with the Administrator on at 11:40 AM. The Administrator was notified he was needed at the facility to help the surveyors obtain information. He stated he was at work and trying to get out and would be at the facility. He stated he was still the Administrator and that he was looking at getting a replacement. The Administrator was not at the facility during the survey from 9:40 AM until 4:25 PM. He was not able to provide additional information.<br><br>Class III | A 080 | | |
| A 083 | 59A-36.011(5) FAC Training - First Aid and .<br><br>(5) FIRST AID AND . ( ). 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.<br>(a) Documentation that the staff member possess | A 083 | | |

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| A 083 | Continued From page 30<br><br>current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement.<br>(b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on employee record review, review of the facility schedule, and staff interview, the facility failed to ensure one staff member working in the facility at all times was trained in First Aid for 1 of 2 sampled employees (Employee A) therefore putting the health and safety of the 6 residents that reside in the facility at risk.<br><br>The findings include:<br><br>On entrance to the facility onn at 9:45 AM, Employee A was observed working alone.<br><br>Record review for Employee A (hired ) found her first aid training expired on .<br><br>The findings were confirmed during an interview with Employee A on at 10:50 AM. She stated she did not have a current First Aid card. She confirmed she worked alone in the facility during the 8:00 AM to 8:00 PM shift. | A 083 | | |

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| A 083 | Continued From page 31<br>Photographic evidence obtained.<br><br>Class III | A 083 | | |
| A 084 | 59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt<br><br>59A-36.011<br>(6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria:<br>(a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance.<br>(b) The training must be provided by a registered | A 084 | | |

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| A 084 | Continued From page 32<br>nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to:<br>1. Read and understand a prescription label;<br>2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including:<br>a. Assist with oral dosage forms, [illegible] dosage forms, and [illegible] and dosage forms;<br>b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions;<br>c. Recognize the need to obtain clarification of an "as needed" prescription order;<br>d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders;<br>e. Complete a medication observation record;<br>f. Retrieve and store medication;<br>g. Recognize the general signs of adverse reactions to medications and report such reactions;<br>h. Assist residents with [illegible] syringes that are prefilled with the proper dosage by a pharmacist and [illegible] that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection;<br>i. Assist with [illegible];<br>j. Use a [illegible] to perform [illegible] testing;<br>k. Assist residents with [illegible] and continuous positive airway pressure (CPAP) devices, excluding the titration of the [illegible] | A 084 | | |

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| A 084 | Continued From page 33<br><br>levels;<br>l. Apply and remove stockings and hosiery;<br>m. Placement and removal of , bags, excluding the removal of the or manipulation of the site; and,<br>n. Measurement of , , rate, temperature, and , rate.<br>(c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online.<br>(d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n.<br><br>429.52<br>(6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training | A 084 | | |

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| A 084 | Continued From page 34<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, staff interview and record review, the facility failed to ensure 1 of 2 sampled employees providing assistance with self-administration of medication completed two hours of the required assistance with self-medication training annually.(Employee A)<br><br>The findings include:<br><br>An observation of Resident 6 was conducted at 11:26 am on . He was with Employee A, Caregiver, who was assisting him with the self-administration of his medication. Employee A retrieved a basket from the medication storage cabinet and brought it to Resident 6, who sat at the dining table. She prepared the monitoring device and after he used it, she retrieved Resident 6's , and announced he would receive 30 units of . She uncapped the needle and handed the , to the resident.<br><br>Record review for Employee A (hired ) found the most recent training in providing assistance with self-administered medications was a 6 hour course on .<br><br>The Owner was notified the employee file did not contain a more recent training. During an interview with the Owner on at 11:37 AM she stated, she called the provider who does the training for the facility to see if she could provide evidence of Employee A's training.<br><br>At the time of exit from the facility on at 4:25 PM the Owner did not have evidence of annual assistance with self-administration training for Employee A. The Administrator had not | A 084 | | |

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| A 084 | Continued From page 35<br><br>arrived at the facility by the time the team left to provide any additional information on Employee A's training.<br><br>Class III | A 084 | | |
| A 085 | 59A-36.011(7) FAC Training - Nutrition & Food Service<br><br>(7) NUTRITION AND FOOD SERVICE. The administrator or person designated by the administrator as responsible for the facility's food service and the day-to-day supervision of food service staff must obtain, annually, a minimum of 2 hours continuing education in topics pertinent to nutrition and food service in an assisted living facility. This requirement does not apply to administrators and designees who are exempt from training requirements under paragraph 59A-36.012(1)(b). A certified food manager, licensed dietician, registered dietary technician or health department sanitarian is qualified to train assisted living facility staff in nutrition and food service.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on employee record review and an interview with the owner, the facility failed to ensure the Administrator/food service designee for the facility obtained a minimum of 2 hour continuing education in food service and nutrition.<br><br>The findings include:<br><br>During an interview with the Owner of the facility on at 3:15 PM, she stated she and the Administrator were responsible for food service at the facility. She was asked for the Administrator's food service training. She stated | A 085 | | |

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| A 085 | Continued From page 36<br><br>the only training she had for the Administrator was in the two files she had provided.<br><br>Record review of the employee files for the Administrator revealed he was hired as the Administrator for the facility on . A review of both files provided by the Owner found no evidence of a two hour food service training.<br><br>At the time of the exit conference at 4:25 PM, the Owner did not have any additional information to provide and the Administrator had not arrived present to provide input.<br><br>Class III | A 085 | | |
| A 093 | 59A-36.012(2) FAC Food Service - Dietary Standards<br><br>(2) DIETARY STANDARDS.<br>(a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are incorporated by reference and available for review at: http://iom.edu/Activities/Nutrition/SummaryDRIs/~/media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%2014.pdf. Therapeutic diets must meet these nutritional standards to the extent possible.<br>(b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food | A 093 | | |

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| A 093 | Continued From page 37<br>habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes.<br>(c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet.<br>1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences.<br>2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents.<br>(d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months.<br>(e) Therapeutic diets must be prepared and served as ordered by the health care provider. | A 093 | | |

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| A 093 | Continued From page 38<br>1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility.<br>2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal.<br>(f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of [illegible] the time between meals.<br>(g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on [illegible].<br>(h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on [illegible] at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must | A 093 | | |

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| A 093 | Continued From page 39<br><br>also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, staff interviews and a review of facility records, the facility failed to ensure menus used were reviewed annually by a licensed or registered dietitian, a licensed nutritionist, a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist. The facility failed to substitute menu items with items of comparable nutritional value, failed to note substitutions before or when the meal is served and to maintain substitutions on file for 6 months.<br><br>The findings include:<br><br>1. On entrance to the facility at 9:45 am on , the menu was observed posted on the wall in the kitchen. It was signed by the Registered Dietician on and was turned to week 2 of a 4 week menu cycle. Employee A, Caregiver, confirmed in an interview at 9:55 am on that this was the current menu she was going by. Photographic evidence was obtained.<br><br>During a tour of the facility at 10:00 am on , it was determined there were 6 residents residing in the home.<br><br>The menu revealed that lunch for the day of survey ( ) was beef stew, noodles, mixed | A 093 | | |

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| A 093 | Continued From page 40<br><br>vegetables, mixed salad and gelatin. Observation of the lunch meal at 12:00 pm on [redacted] revealed the residents were each served 2 to 3 large slices of pepperoni pizza and coffee and/or juice. No green salad or vegetable was served, nor was gelatin.<br><br>At 12:57 pm on [redacted], Employee A was asked where she documented menu substitutions. She said "I just look at the menu. Today is Wednesday." The menu was reviewed with her and it called for beef stew today. She confirmed that and confirmed residents had pizza today. She was asked again for the substitution log but no log was produced.<br><br>In an interview with Employee D, Caregiver, 1:00 pm on [redacted], she stated she had been working on taking over the Administrator duties for about 2 months. She reviewed the menu. Employee D confirmed it had not been reviewed by the dietician annually, as required. She was asked for the substitution log. She said it was here somewhere, but could not produce any log by the end of the survey.<br><br>Class III | A 093 | | |
| A 152 | 59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other<br><br>(3) OTHER REQUIREMENTS.<br>(a) All facilities must:<br>1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.;<br>2. Be maintained free of hazards; and, | A 152 | | |

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| A 152 | Continued From page 41<br><br>3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order.<br>(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:<br>1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident,<br>2. A closet or wardrobe space for hanging clothes,<br>3. A dresser, or other furniture designed for storage of clothing or personal effects,<br>4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and,<br>5. A comfortable chair, if requested.<br>(c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency.<br>(d) Residents who use portable bedside commodes must be provided with privacy during use.<br>(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 .<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observations and interviews with staff and residents, the facility failed to ensure a safe living environment with readily accessible egress in the event of a fire or other emergency requiring evacuation. This placed all 6 residents at a risk in the event they needed to exit the facility | A 152 | | |

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| A 152 | Continued From page 42<br>immediately.<br><br>The findings include:<br><br>On entrance to the facility at 9:45 am on , the interior of the front door was observed to have a key-operated deadbolt lock. A key on a long red lanyard was observed hanging from the lock. A large "Exit" sign was posted above the front door, indicating it was an emergency exit. A plastic baby gate was observed hanging at - across the kitchen doorway. A sign on the gate instructed "STAFF ONLY, RESIDENTS ARE NOT ALLOWED." Photographs were obtained.<br><br>During a tour of the facility at 10:00 am on , it was determined there were 6 residents residing in the home. One Caregiver was on duty at that time.<br><br>At 10:25 am on , a resident stated the door was not opening. The Owner, who arrived after the survey commenced, then tried to open the door, with no success. She then removed the key from the front door and took it to the sliding glass door to attempt to unlock it. Observation of the door found a large "Exit" sign posted above, indicating it was also an emergency exit. The front door was checked at this time and was discovered to be locked.<br><br>At 11:10 am on , several residents gathered in the living room and were visiting with each other. The front door was checked at this | A 152 | | |

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| A 152 | Continued From page 43<br>time. It remained locked with no key in the deadbolt. Residents 2, 3, 4, 5, and 6 were asked which of them had a key to the front door. Resident 6 stated that the key was usually hanging on the wall in the kitchen from the long red cord. He did not have a personal key. Residents 2 and 4 also confirmed they did not have keys to the lock. Observation of the kitchen at this time found no key hanging anywhere.<br><br>Observations of the front door were conducted at 11:45 am, 2:35 pm, and 3:24 pm on . . . . . Each observation found the door remained locked, with no key in the deadbolt. There was no key hanging in the kitchen at any of the referenced times.<br><br>At 12:35 pm on , the door partially opened when pushed, but would not move further in it's track.<br><br>An interview was conducted with Employee D, Caregiver, at 3:30 pm on . She had arrived at the facility at 1:00 pm to assist with the survey. Employee D confirmed the front door was locked much of the time. She said sometimes it was unlocked and sometimes the key was left in the door, but the residents did not have their own key(s). Employee D confirmed the front door was a fire exit. She also confirmed the key was stored in the kitchen drawer. Employee D acknowledged the sign on the gate prohibited residents from entering the kitchen.<br><br>An interview was conducted with Employee A, Caregiver, at 3:20 pm on . She stated | A 152 | | |

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| A 152 | Continued From page 44<br><br>she kept the front door locked at all times when the residents were home. The residents did not have a key. Employee A said she kept the key in the drawer in the baker's rack in the kitchen. She was asked what would happen if a fire broke out and she was not able to safely get to the key. She stated she would have to go around the house. When reminded that if the door was locked from the inside and the key in the kitchen, she would not be able to open the front door from the outside. Employee A said she would have to try to open the window.<br><br>Class III | A 152 | | |
| A 160 | 59A-36.015(1) FAC Records - Facility<br><br>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.<br>(1) FACILITY RECORDS. Facility records must include:<br>(a) The facility's license displayed in a conspicuous and public place within the facility.<br>(b) An up-to-date admission and discharge log listing the names of all residents and each resident's:<br>1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident | A 160 | | |

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| A 160 | Continued From page 45<br>was admitted with a [illegible]; and,<br>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].<br>(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).<br>(d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in rule 59A-36.019, F.A.C., that must be readily available by facility staff.<br>(e) The facility's liability insurance policy required in rule 59A-36.013, F.A.C.<br>(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.<br>(g) The admission package presented to new or prospective residents (less the resident's contract) described in rule 59A-36.006, F.A.C.<br>(h) If the facility advertises that it provides special care for persons with 's or related [illegible], a copy of all such facility advertisements as required by section 429.177, F.S.<br>(i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in rule 59A-36.007, F.A.C.<br>(j) All food service records required in rule 59A-36.012, F.A.C., including menus planned | A 160 | | |

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| A 160 | Continued From page 46<br><br>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.<br>(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.<br>(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.<br>(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.<br>(n) The facility's resident elopement response policies and procedures.<br>(o) The facility's documented resident elopement response drills.<br>(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.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, record review, and interview, the facility failed to maintain an up-to-date admission and discharge log for 1 of 6 residents residing at the facility (Resident #4) and failed to maintain a comprehensive emergency management plan at the facility affecting the safety of 6 out of the 6 residents residing in the facility. | A 160 | | |

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| A 160 | Continued From page 47<br><br>The findings include:<br><br>1. During a tour of the facility on . . . . . at 10:00 AM six residents were observed living in the facility. A review of the facility's admission and discharge log found 5 residents were listed as still living in the facility. Resident 4's name was not on the log.<br><br>During an interview with Caregiver A on . . . . . at 12:50 PM, she was asked for Resident 4's record and when he was admitted to the facility. She pulled out the medication observation records for Resident 4 that showed he received medication at the facility beginning . During an interview with Resident 4 on . . . . . at 12:55 PM, he was asked when he was admitted to the facility. He stated about three months ago and he guessed around . . . . . .<br><br>2. During an interview with the Owner of the facility on at 10:13 AM, she was asked for a copy of the building's comprehensive emergency management plan (CEMP) and approval letter. She stated she did not have the CEMP approval letter or the CEMP at the facility.<br><br>Class III | A 160 | | |
| A 162 | 59A-36.015(3) FAC Records - Resident<br><br>(3) RESIDENT RECORDS. Resident records must be maintained on the premises and include:<br>(a) Resident demographic data as follows:<br>1. Name,<br>2. ,<br>3. Race, | A 162 | | |

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| A 162 | Continued From page 48<br>4. Date of birth,<br>5. Place of birth, if known,<br>6. Social security number,<br>7. Medicaid and/or Medicare number, or name of other health insurance . . ,<br>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,<br>9. Name, address, and telephone number of the health care provider and case manager, if applicable.<br>(b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C.<br>(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.<br>(d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable.<br>(e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C.<br>(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.<br>(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 such consent is not included in the resident's contract.<br>(h) For facilities that manage a pill organizer, assist with self-administration of medications or | A 162 | | |

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| A 162 | Continued From page 49<br>administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C.<br>(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.<br>(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.<br>(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.<br>(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.<br>(m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable.<br>(n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C.<br>(o) The resident's , DH Form 1896, if applicable. | A 162 | | |

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| A 162 | Continued From page 50<br><br>(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:<br>1. A log listing the names of residents participating in this arrangement,<br>2. The resident demographic data required in this paragraph,<br>3. The health assessment described in rule 59A-36.006, F.A.C.,<br>4. The resident's contract described in rule 59A-36.018, F.A.C.; and,<br>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.<br>(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.<br>(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.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, review of resident records and interview with staff, the facility failed to maintain complete and accurate resident health assessments (AHCA form 1823s) for 3 of 3 | A 162 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11968482 | A. BUILDING: _____ B. WING _____ | 10/27/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LOVING ANGELS ASSISTED LIVING LLC | 9 RAMBLE WAY PALM COAST, FL 32164 |

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| A 162 | Continued From page 51<br><br>residents whose records were reviewed (Residents 2, 3 and 6), and failed to obtain ( ), for 1 of 2 residents reviewed. (Resident # 3) out of a total of 6 residents in the sample.<br><br>The findings include:<br><br>1. An observation of Resident 6 was conducted at 11:26 am on . He was with Employee A, Caregiver, who was assisting him with the self-administration of his medication. Employee A retrieved a basket from the medication storage cabinet and brought it to Resident 6, who sat at the dining table. After inserting a lancet into a spring loaded lancing device (a device used by to penetrate the skin in order to obtain a sample for testing), she handed the device to the resident. He placed the device on the tip of his left pointer , deployed the lancet, and placed a drop of his onto the wicking strip on a meter. Employee A retrieved Resident 6's , and announced he would receive 30 units of . She uncapped the needle and handed the to the resident. Resident 6 dialed the pen to 30 units, which was confirmed visually by this writer. Without assistance, Resident 6 injected the into the left side of his abdomen.<br><br>Record review for Resident 6 revealed an AHCA form 1823 (Resident Health Assessment) dated . Resident 6 was noted as , requiring frequent reminders. He required assistance with activities of daily living and daily oversight for his wellbeing. Section C. of the | A 162 | | |

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| A 162 | Continued From page 52<br><br>assessment stated he required 24 hour nursing care and that his needs could not be met in an assisted living facility. Page 4. noted Resident 6 needed to have his medications administered for him. Page 5. of the assessment, which is intended to be completed by the Administrator to list the services provided by the facility, was missing altogether. Further review of the record confirmed Resident 6 had a diagnosis of . Photographic evidence was obtained.<br><br>An interview was conducted with the owner at 1:54 pm on . She reviewed Resident 6's health assessment and stated maybe she took out page 5. to have Employee D sign it. She acknowledged the Administrator was supposed to sign it. She also acknowledged the assessment indicated Resident 6 required medication administration but was observed to self-administer his own , and that he was noted to need 24-hour nursing services and was not appropriate for an assisted living facility.<br><br>2. Record review for Resident 2 revealed an AHCA 1823 dated . Resident 2 was noted to be slow and resentful, with mental related to . The 5-page form was incomplete, as it only contained pages 1 and 4. The form omitted the sections asking the following: Her elopement risk status; the level of assistance she needed with activities of daily living; dietary instructions; communicable status; status; whether or not she presented a danger to herself or others; whether or not she required 24-hour nursing or care; whether or not her needs could be met in an assisted living facility; her ability to perform self-care and independent living tasks; and, her | A 162 | | |

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| A 162 | Continued From page 53<br>need for general oversight. The last page, which is intended to be completed by the Administrator to list services the facility would provide this resident, was missing.<br><br>An interview was conducted with Employee D, Caregiver, at 2:15 pm. She reviewed the assessment and confirmed the missing pages and required information.<br><br>2. Record review of the AHCA 1823 Resident Health Assessment for Resident #3 based on a evaluation found Page 5 was missing. The last page, which is intended to be completed by the Administrator to list services the facility would provide this resident, was missing.<br><br>The findings were confirmed during an interview with the Owner of the facility on at 1:55 PM. She stated she may have taken it out of the resident record so the Administrator could sign it.<br><br>3. Record review for Resident #3 revealed he was admitted to the facility on and signed a paper on that he had a . (Photographic evidence obtained.) Further record review for Resident #3 found no evidence of a in his resident file.<br><br>Caregiver A was asked for the for Resident #3 on at 12:18 PM. She was observed going into the garage. When she returned from the garage at 12:20 PM she was | A 162 | | |

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| A 162 | Continued From page 54<br><br>asked if the facility had a book. She stated she did not have anything to provide.<br><br>The Owner came to the facility on at 1:00 PM. She was asked for the info for Resident #3. She stated he did not have anything and that he was full code. She was shown the paper the resident's POA signed stating the resident had a . She stated she spoke to the POA for Resident #3. She stated she did not know when and the POA did not have any paperwork provide.<br><br>Class III | A 162 | | |

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| CZ816 | 408.809(2a-c) 435.05(2) 59A-35.090(2d-3c Background Screening-Compliance Attestation<br><br>408.809 Background screening; prohibited offenses.-<br>(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 ␣␣␣. The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or | CZ816 | | |

AHCA Form 3020-0001

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

Agency for Health Care Administration

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| CZ816 | Continued From page 1<br><br>professional licensure requirements of 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:<br>(a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section;<br>(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<br>(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.<br><br>435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers:<br>(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.<br><br>59A-35.090 Background Screening.<br>(2) Processing Screening Requests, Required Documents and Fees.<br>(d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, , herein incorporated by reference, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-09106, and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Service | CZ816 | | |

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| CZ816 | Continued From page 2<br><br>s/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.<br>(e) An administrator or chief financial officer must be screened and qualified prior to to the position.<br>(3) Results of Screening and Notification.<br>(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.<br>(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.<br>(c) The eligibility results of employee screening and the signed Attestation referenced in subsection 59A-35.090(2), F.A.C., must be in the employee's personnel file, maintained by the provider.<br><br>This Statute or Rule is not met as evidenced by: | CZ816 | | |

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| CZ816 | Continued From page 3<br><br>Based on record review and an interview with the Owner, the facility failed to ensure an Attestation of Compliance with Background Screening Requirements, was obtained and kept in the employee file for 2 of 3 employees reviewed. (Employees B and C)<br><br>The findings include:<br><br>Record review for Employee B (hired ) found no evidence of an Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008 in the employee record.<br><br>Record review for the Administrator (hired ) found no evidence of an Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008 in the employee record.<br><br>The Owner was notified of the missing information. The Owner left the facility around 11:30 AM and 2:30 PM to look for additional employee records and was not able to provide the attestations. At the time of the exit conference at 4:25 PM on , the Owner did not have any additional information to provide.<br><br>Unclassified | CZ816 | | |
| CZ830 | 408.821 FS Emergency Management Planning<br><br>408.821 Emergency management planning; emergency operations; inactive license.-<br>(1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for | CZ830 | | |

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| CZ830 | Continued From page 4<br><br>emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows:<br>(a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan.<br>(b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan.<br>(c) Submit necessary plan revisions within 30 days after notification that plan revisions are required.<br>(d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health.<br>(2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers.<br>(3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider:<br>1. Suffered damage to its operation during the state of emergency.<br>2. Is currently licensed. | CZ830 | | |

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| CZ830 | Continued From page 5<br><br>3. Does not have a provisional license.<br>4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months.<br>(b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes.<br>(4) The agency may adopt rules relating to emergency management planning, communications, and operations. Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations.<br><br>This Statute or Rule is not met as evidenced by: | CZ830 | | |

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| CZ830 | Continued From page 6<br><br>Based on an interview with the owner of the facility and a review of the Agency for Health Care Administration Emergency Status System (ESS), the facility failed to ensure the safety of its 6 current residents, by failing to report the following information using the online database (ESS): facility census, available beds, inventory, needs, and other related information for Novel Coronavirus (COVID-19) daily by 10:00 AM, pursuant to Executive Order 20-51, and at the direction of the State Surgeon General, for 8 of 28 most recent days reviewed.<br><br>The findings include:<br>Record review of the ESS submissions from through revealed the facility failed to make submissions on , , , , , , and .<br><br>During an interview with the owner on at 3:14 PM, she stated she updates ESS. She stated does the updates for the facility along with her other facilities. She stated sometimes does not save the information or go to check to see the information was updated. She was given the dates of the missing submissions and she stated she was aware they were missing.<br><br>Pursuant to the Governor's Executive Order 20-51, and at the direction of the State Surgeon General regarding Novel Coronavirus (COVID-19), the Agency for Health Care Administration opened the event "COVID-19 Monitoring" in the Emergency Status System to monitor assisted living facilities census, inventory, needs and other related information statewide. All assisted living facilities were required to report current resident census and available beds in their facilities by 10:00 AM and answer additional | CZ830 | | |

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| CZ830 | Continued From page 7<br>questions related to the facility status and COVID-19. Notification to facilities was dated<br>Class | CZ830 | | |

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| A 000 | Initial Comments<br><br>An unannounced biennial licensure survey, and . . . . . Control Focused survey was conducted at Loving Angels Assisted Living from to . . . . . Deficiencies were found at the time of the visit. | A 000 | | |
| A 008 | 429.26( ) FS; 59A-36.006(2) FAC Admissions - Health Assessment<br><br>429.26<br>(5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must 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 to or continued residency in the facility. The medical examination form may only be used to record the practitioner's direct observation of the patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form, reflecting the resident's condition on the date the examination is performed, becomes a permanent part of the facility's record of the resident and must be made | A 008 | | |

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| LOVING ANGELS ASSISTED LIVING LLC | 9 RAMBLE WAY PALM COAST, FL 32164 |

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| A 008 | Continued From page 1<br>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.<br>(6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and must 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 provided that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or her responsibilities under subsection (1). Further, Department of | A 008 | | |

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| A 008 | Continued From page 2<br><br>Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of [illegible] require such assistance.<br><br>59A-36.006<br>(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.<br>(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:<br>1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations,<br>2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living,<br>3. Any nursing or [illegible] services required by the individual,<br>4. Any special diet required by the individual,<br>5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication,<br>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,<br>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 | A 008 | | |

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| A 008 | Continued From page 3<br><br>assisted living facility; and,<br>8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care provider. The medical examination may be conducted by a health care provider licensed under chapter 458, 459 or 464, F.S.<br>(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, [illegible], 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.<br>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.<br>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.<br>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.<br>(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 | A 008 | | |

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| A 008 | Continued From page 4<br><br>days after admission.<br>(d) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b).<br>(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.<br>(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<br>Form, for residents who do not wish<br>to be administered<br>in the case of or<br>(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.<br><br>This Statute or Rule is not met as evidenced by: | A 008 | | |

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| A 008 | Continued From page 5<br><br>Based on observation, review of resident records and interview with staff, the facility failed to maintain complete and accurate resident health assessments (AHCA form 1823s) for 2 of 3 residents whose records were reviewed (Residents 2 and 6).<br><br>The findings include:<br><br>1. An observation of Resident 6 was conducted at 11:26 am on . He was with Employee A, Caregiver, who was assisting him with the self-administration of his medication. Employee A assisted Resident 6 with the set up on his . When handed the , , Resident 6 dialed the pen to 30 units. Without assistance, Resident 6 injected the into the left side of his abdomen.<br><br>Record review for Resident 6 revealed an AHCA form 1823 (Resident Health Assessment) dated . Resident 6 was noted as , requiring frequent reminders. He required assistance with activities of daily living and daily oversight for his wellbeing. Section C. of the assessment stated he required 24 hour nursing care and that his needs could not be met in an assisted living facility. Page 4. noted Resident 6 needed to have his medications administered for him. Page 5. of the assessment, which is intended to be completed by the Administrator to list the services provided by the facility, was missing altogether. Further review of the record confirmed Resident 6 had a diagnosis of . . . . . Photographic evidence was obtained.<br><br>An interview was conducted with the Owner at | A 008 | | |

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| A 008 | Continued From page 6<br><br>1:54 pm on [redacted]. She reviewed Resident 6's health assessment and stated maybe she took out page 5. to have Employee D sign it. She acknowledged the Administrator was supposed to sign it. She also acknowledged the assessment indicated Resident 6 required medication administration but was observed to administer his own with only some assistance from Employee A, and that he was noted to need 24-hour nursing services and was not appropriate for an assisted living facility.<br><br>2. Record review for Resident 2 revealed an AHCA 1823 dated [redacted]. The 5-page form was incomplete, as it only contained pages 1 and 4. The form omitted the sections asking the following: Her elopement risk status; the level of assistance she needed with activities of daily living; dietary instructions; communicable status; [redacted] status; whether or not she presented a danger to herself or others; whether or not she required 24-hour nursing or [redacted] care; whether or not her needs could be met in an assisted living facility; her ability to perform self-care and independent living tasks; and, her need for general oversight. The last page, which is intended to be completed by the Administrator to list services the facility would provide this resident, was missing.<br><br>An interview was conducted with Employee D, Caregiver, at 2:15 pm. She reviewed the assessment and confirmed the missing pages and required information.<br><br>Class III | A 008 | | |

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| A 032 | Continued From page 7 | A 032 | | |
| A 032 | 59A-36.007(8) FAC Resident Care - Elopement Standards<br><br>59A-36.007<br>(8) ELOPEMENT STANDARDS.<br>(a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days.<br>1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times.<br>2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the | A 032 | | |

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| A 032 | Continued From page 8<br><br>resident's representative.<br>(b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for:<br>1. An immediate search of the facility and premises,<br>2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities,<br>3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and,<br>4. The continued care of all residents within the facility in the event of an elopement.<br>(c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to sections 429.41(1)(a)3. and 429.41(1)(l), F.S.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interviews the facility failed conduct elopement drills with staff twice per year for two of two years reviewed.<br><br>The findings include:<br><br>A review of the elopement drill book provided by Employee D on . . . . . at 2:25 PM revealed the most recent elopement drill was conducted on . . . . . and . . . . . Photographic evidence obtained.<br><br>During an interview with Employee B on | A 032 | | |

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| A 032 | Continued From page 9<br><br>at 2:09 PM she was asked if she had participated in an elopement drill and she stated she had not. Records indicated Employee B was hired .<br><br>During an interview with Employee D on at 2:40 PM, she confirmed the most recent elopement drill in the elopement book was on . Employee D was asked when she last participated in an elopement drill and she stated could not recall and that they were due for one.<br><br>During an interview with the Owner of the facility on at 4:11 PM she was notified the elopement drill book was not up to date. She did not have any other evidence showing the facility was conducting elopement drills to provide.<br><br>Class III | A 032 | | |
| A 076 | 59A-36.009 FAC<br>( )<br><br>(1) POLICIES AND PROCEDURES.<br>(a) Each assisted living facility must have written policies and procedures that explain its implementation of state laws and rules relative to ( ). An assisted living facility may not require execution of a as a condition of admission or treatment. The assisted living facility must provide the following to each resident, or resident's representative, at the time of admission:<br>1. Form SCHS- , "Health Care Advance Directives - The Patient's Right to Decide," , , or with a copy of some other substantially similar document, which incorporates information | A 076 | | |

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| A 076 | Continued From page 10<br>regarding advance directives included in chapter 765, F.S. Form SCHS- is available from the Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 34, Tallahassee, FL 32308 or the agency's website at: http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/HC_Advance_Directives/docs/adv_dir.pdf; and,<br>2. DH Form 1896, Florida Form, , 2004, which is hereby incorporated by reference. This form may be obtained by calling the Department of Health's toll free number 1(800)226-1911, extension 2780 or online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04005.<br>(b) There must be documentation in the resident's record indicating whether a DH Form 1896 has been executed. If a DH Form 1896 has been executed, a yellow copy of that document must be made a part of the resident's record. If the assisted living facility does not receive a copy of a resident's executed DH Form 1896, the assisted living facility must document in the resident's record that it has requested a copy.<br>(c) The executed DH Form 1896 must be readily available to medical staff in the event of an emergency.<br>(2) LICENSE REVOCATION. An assisted living facility's license is subject to revocation pursuant to section 408.815, F.S., if, as a condition of treatment or admission, the facility requires an individual to execute or waive DH Form 1896.<br>(3) PROCEDURES. Pursuant to section 429.255, F.S., an assisted living facility must honor a properly executed DH Form 1896 as follows:<br>(a) In the event a resident experiences or , staff trained in , | A 076 | | |

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| A 076 | Continued From page 11<br>( ) or a health care provider present in the facility, may withhold ( and ).<br>(b) In the event a resident is receiving hospice services and experiences or , facility staff must immediately contact hospice staff. The hospice procedures take precedence over those of the assisted living facility.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, review of resident records and interview with staff, the facility failed to obtain ( 's), for 1 of 2 residents reviewed. (Resident 3) out of a total of 6 residents in the sample.<br><br>The findings include:<br><br>Record review for Resident 3 revealed he was admitted to the facility on and signed a paper on that he had a . (Photographic evidence obtained.) Further record review for Resident 3 found no evidence of a in his resident file.<br><br>Caregiver A was asked for the for Resident 3 on at 12:18 PM. She was observed going into the garage. When she returned from the garage at 12:20 PM she was asked if the facility had a book. She stated she did not have anything to provide.<br><br>On at 1:00 PM the Owner was asked for the info for Resident 3. She stated he did not have anything and that he was full code. She was shown the paper the resident's POA signed stating the resident had a . She | A 076 | | |

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| A 076 | Continued From page 12<br><br>stated she spoke to the POA for Resident 3. She stated she did not know when and the POA did not have any paperwork provide.<br><br>Class III | A 076 | | |
| A 077 | 429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators<br><br>429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements.<br><br>429.52<br>(4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule.<br>(5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years.<br><br>59A-36.010<br>(1) ADMINISTRATORS. Every facility must be | A 077 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| LOVING ANGELS ASSISTED LIVING LLC | 9 RAMBLE WAY PALM COAST, FL 32164 |

| (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 |
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| A 077 | Continued From page 13<br>under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter.<br>(a) An administrator must:<br>1. Be at least [illegible];<br>2. If employed on or after [illegible], have, at a minimum, a high school diploma or G.E.D.;<br>3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.;<br>4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to [illegible], are not required to take the competency test unless specified elsewhere in this rule; and,<br>5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department.<br>(b) In the event of extenuating circumstances, such as the [illegible] of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: | A 077 | | |

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| A 077 | Continued From page 14<br>1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and,<br>2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility.<br>(c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities.<br>(d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility.<br>(e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: | A 077 | | |

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| A 077 | Continued From page 15<br><br>http://www.flrules.org/Gateway/reference.asp?No=Ref-09393.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on interviews observations and interviews with staff and residents, the Administrator failed to supervise and hold responsibility for the operation and maintenance of the facility including the management of all staff and the provision of care to residents. The facility failed to ensure operational matters were conducted by qualified individuals in the Administrator's absence. This has the potential to affect all 6 residents of the facility.<br><br>The findings include:<br><br>On entrance to the facility at 9:45 am on [redacted], Employee A, Caregiver, was asked to notify the Administrator of the survey commencement. Instead, Employee A notified the Owner. At this time, the Owner was asked to notify the Administrator of the survey's commencement.<br><br>Resident 6 was interviewed on [redacted] at 9:58 am. He stated he would go to the Owner if he had any concerns but the Owner was hardly ever at the facility. Resident 6 stated he never saw the facility Administrator. He explained it was Employee A who was here everyday, she comes early in the morning and leaves about 7:00 pm at night. There was only one staff person in the facility during the day.<br><br>An interview was conducted with Resident 2 at | A 077 | | |

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| A 077 | Continued From page 16<br><br>10:00 am on [redacted]. She was asked if she ever saw the Administrator in the facility. She replied not that much. She only sees the Owner. The Administrator comes every 3 weeks for 1/ 2 hour to an hour. The Owner was the one who was here and she was who the residents contacted for all of their needs. When asked who she would report a problem to if she had one, she replied the Owner. If unable to rectify the problem, the Owner would then call the Administrator to come and fix it.<br><br>The facility Owner arrived at 10:15 am on [redacted], but the Administrator still had not arrived. A telephone interview was conducted with the Administrator at approximately 11:00 am on [redacted]. He stated he would come to the facility to assist with the licensure survey.<br><br>An interview was conducted with Employee A, Caregiver, at 10:40 am on [redacted]. She stated when the Administrator did arrive in the building, it was usually from 7:00 pm to 8:00. She would not specify what days or how frequently he came, or what involvement he had in the day to day operations of the facility.<br><br>An interview was conducted with Resident 4 at 12:40 pm on [redacted]. He was asked who he would report a problem to, should he have one. He replied, the Owner. She was here weekly. He stated the Administrator was Employee D (a Caregiver). She was here 5 days a week. Resident 4 stated the Administrator of record came to the facility once a week whenever they needed something fixed. He was not here very often. | A 077 | | |

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| A 077 | Continued From page 17 | A 077 | | |

At 1:00 pm on [redacted], Employee D, Caregiver, arrived. She introduced herself and stated she had been working on taking over the Administrator's duties for approximately 2 months or so. She had not taken the core training test yet.

At approximately 2:00 pm on [redacted], the Owner was asked where the Administrator was, as he had not yet arrived. She explained he was working. She stated he worked full time elsewhere.

Throughout the survey from 10:15 am to 4:30 pm on [redacted], the Owner assisted with obtaining needed and missing information for the survey team, departing the facility in her car several times to look for needed information. She was never heard consulting with the Administrator via telephone to ask for the location for missing documents.

Review of the Final Order for case number 2015010450 revealed the Owner was listed in the terms of the settlement agreement. She was not to have ownership interest in the facility, be a "controlling interest" in the facility, or have control, directly or indirectly, in the day to day operation of the facility.

In a final interview with the Owner at 4:30 pm on [redacted], she was asked who was really providing oversight to the facility, given she had been the only one assisting the survey team

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| A 077 | Continued From page 18<br><br>during the inspection. She was asked directly if assumed the responsibilities of the Administrator of this facility. She stated she was in the process of replacing her Administrator with Employee D, who had been core trained. She was hopeful Employee D would pass her test. The Owner was asked directly if she was the person actually providing administrative oversight to this facility and she nodded her yes.<br><br>By the time the team exited the facility at 4:30 pm on , the Administrator had not arrived.<br><br>2. Record review of the Administrator's employee file revealed he was hired on . Because no evidence of core training was found in the record, the owner was asked to produce evidence he maintained his core certification. She left the facility around 2:30 PM on and returned about 45 minutes later with the certification number of 171239970 issued .<br><br>Further record review of the employee file for the Administrator found the only evidence of training since was a 6 hour medication training on and a 1 hour first aid training on .<br><br>In an interview with Employee A at 10:40 am on , she stated she worked Mondays, Wednesdays and Fridays from 8:00 am - 8:00 pm. Employee D worked the same shift on Tuesdays, Thursdays and Saturdays. Employee B worked the overnight shifts. Record review for Employee A (hired ) found her first aid training expired on . | A 077 | | |

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| A 077 | Continued From page 19<br><br>The findings were confirmed during an interview with Employee A on at 10:50 AM. She stated she did not have a current First Aid card. She confirmed she worked alone in the facility during the 8:00 AM to 8:00 PM shift.<br><br>Review of the facility schedules for and found there were 2 sets of staff initials were written in each day; one set of initials on the top and one set on the bottom of each calendar day. There were no hours specified on the schedule for any of the staff initials. The schedule indicated one to two staff member were scheduled to work per day. The initials were for direct care staff and the Administrator's initials were not present. Photographic evidence was obtained.<br><br>Based on a census of residents, the minimum staffing hours required for is 212 hours per week. of the scheduled hours for to and for to found only 168 staffing hours were provided weekly for the 6 residents.<br><br>An interview was conducted with the Owner at 4:13 pm on because the facility Administrator was not present during the survey. She reviewed the schedules and acknowledged the staffing hours 44 hours short of the minimum weekly requirement for the current census of 6.<br><br>Class III | A 077 | | |
| A 079 | 59A-36.010(3) FAC Staffing Standards - Levels | A 079 | | |

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| A 079 | Continued From page 20<br><br>(3) STAFFING STANDARDS.<br>(a) Minimum staffing:<br>1. Facilities must maintain the following minimum staff hours per week:<br><br>Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week<br>0-5 168<br>6-15 212<br>16-25 253<br>26-35 294<br>36-45 335<br>46-55 375<br>56-65 416<br>66-75 457<br>76-85 498<br>86-95 539<br><br>For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week.<br>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.<br>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.<br>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. | A 079 | | |

Agency for Health Care Administration

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| A 079 | Continued From page 21<br>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.<br>a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement.<br>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 .<br>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.<br>7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement.<br>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.<br>9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. | A 079 | | |

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| A 079 | Continued From page 22<br>(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.<br>(c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives.<br>(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.<br>1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time | A 079 | | |

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| A 079 | Continued From page 23<br><br>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.<br>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.<br>(e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios.<br>(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.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observations, interviews with residents and staff and review of employee schedules, the facility failed to ensure sufficient staffing per week for the census of 6 residents.<br><br>The findings include:<br><br>On arrival to the facility on . . . . . at 9:45 am Employee A, Caregiver, was present and working alone. During the tour of the facility at 10:00 am on , it was determined there were 6 | A 079 | | |

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| A 079 | Continued From page 24<br><br>residents residing in the home. Resident 1 was observed in her bed and did not respond to the surveyor's presence or greetings. Employee A explained at this time that Resident 1 was on hospice services and required total care.<br><br>During and interview with Resident 6 on [redacted] at 9:58 am, he stated Employee A, caregiver, was here every day. She came in early in the morning and left about 7:00 at night. There was only one staff person at a time in the facility during the day.<br><br>In an interview with Employee A at 10:40 am on [redacted], she stated she worked Mondays, Wednesdays and Fridays from 8:00 am - 8:00 pm. Employee D worked the same shift on Tuesdays, Thursdays and Saturdays. Employee B worked the overnight shifts. Review of the schedules at this time found the [redacted] schedule was not in the binder. Employee A was asked to locate it, but was unable to do so.<br><br>Review of the facility schedules for [redacted] and [redacted] found there were 2 sets of staff initials were written in each day; one set of initials on the top and one set on the bottom of each calendar day. There were no hours specified on the schedule for any of the staff initials. The [redacted] schedule read as follows:<br><br>Sundays: Employee D and Employee B's initials were present with no specific times.<br>Mondays: Employee A's initials were present with no specific times.<br>Tuesdays: Employee D and Employee B's initials | A 079 | | |

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| A 079 | Continued From page 25<br>were present with no specific times.<br>Wednesdays: Employee A and Employee A's initials were present with no specific times.<br>Thursdays: on , only Employee D was marked, with no specific times. All other Thursdays noted Employee D and Employee B's initials with no specific times.<br>Fridays: Employee A and Employee E's initials were present with no specific times.<br>Saturday: Employee D and Employee B's initials were present with no specific times.<br><br>Review of the schedules for revealed the following:<br><br>Sundays: Employee D and Employee B's initials were present with no specific times.<br>Mondays: Employee A's initials were present with no specific times.<br>Tuesdays: Employee D and Employee B's initials were present with no specific times.<br>Wednesdays: Employee A's initials were present with no specific times.<br>Thursdays: Employee D and Employee B's initials were present with no specific times.<br>Fridays: Employee A and Employee E's initials were present with no specific times.<br>Saturday: Employee D and Employee B's initials were present with no specific times.<br><br>Photographic evidence was obtained.<br><br>Based on a census of residents, the minimum staffing hours required for is 212 hours per week. of the scheduled hours for to and for to found only | A 079 | | |

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| LOVING ANGELS ASSISTED LIVING LLC | 9 RAMBLE WAY PALM COAST, FL 32164 |

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| A 079 | Continued From page 26<br>168 staffing hours were provided weekly for the 6 residents.<br><br>An interview was conducted with the Owner at 4:13 pm on because the facility Administrator was not present during the survey. She reviewed the schedules and acknowledged the staffing hours 44 hours short of the minimum weekly requirement for the current census of 6.<br><br>Class III | A 079 | | |
| A 080 | 429.52( ) FS; 59A-36.011(1) FAC Training - Core & Competency Test<br><br>429.52<br>(2) Administrators and other assisted living facility staff must meet minimum training and education requirements established by the agency by rule. This training and education is intended to assist facilities to appropriately respond to the needs of residents, to maintain resident care and facility standards, and to meet licensure requirements.<br>(3) The agency, in conjunction with providers, shall develop core training requirements for administrators consisting of core training learning objectives, a competency test, and a minimum required score to indicate successful passage of the core competency test. The required core competency test must cover at least the following topics:<br>(a) State law and rules relating to assisted living facilities.<br>(b) Resident rights and identifying and reporting , neglect, and , .<br>(c) Special needs of elderly persons, persons with | A 080 | | |

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| A 080 | Continued From page 27<br>mental illness, and persons with . . . . , . . . . and how to meet those needs.<br>(d) Nutrition and food service, including acceptable sanitation practices for preparing, storing, and serving food.<br>(e) Medication management, recordkeeping, and proper techniques for assisting residents with self-administered medication.<br>(f) Fire safety requirements, including fire evacuation drill procedures and other emergency procedures.<br>(g) Care of persons with 's and related . . . . . .<br><br>59A-36.011<br>(1) ASSISTED LIVING FACILITY CORE TRAINING REQUIREMENTS AND COMPETENCY TEST.<br>(a) The assisted living facility core training requirements established by the department pursuant to section 429.52, F.S., shall consist of a minimum of 26 hours of training plus a competency test.<br>(b) Administrators and managers must successfully complete the assisted living facility core training requirements within 3 months from the date of becoming a facility administrator or manager. Successful completion of the core training requirements includes passing the competency test. The minimum passing score for the competency test is 75%. Administrators who have attended core training prior to . , . . , and managers who attended the core training program prior to , . . , shall not be required to take the competency test. Administrators licensed as nursing home administrators in accordance with chapter 468, part II, F.S., are exempt from this requirement.<br>(c) Administrators and managers shall participate | A 080 | | |

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| A 080 | Continued From page 28<br><br>in 12 hours of continuing education in topics related to assisted living every 2 years.<br>(d) A newly hired administrator or manager who has successfully completed the assisted living facility core training and continuing education requirements, shall not be required to retake the core training. An administrator or manager who has successfully completed the core training but has not maintained the continuing education requirements will be considered a new administrator or manager for the purposes of the core training requirements and must:<br>1. Retake the assisted living facility core training; and,<br>2. Retake and pass the competency test.<br>(e) The fees for the competency test shall not exceed $200.00. The payment for the competency test fee shall be remitted to the entity administering the test. A new fee is due each time the test is taken.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on employee record review and an interview with the owner, the facility failed to ensure the Administrator participated in 12 hours of continuing education in topics related to assisted living every 2 years.<br><br>The findings include:<br><br>Record review of the employee file for the Administrator revealed he was hired as the Administrator of the facility on . Further record review of his employee file found no evidence of Core training. The owner was notified that the Administrators employee file was missing his core training. The owner left the facility around 2:30 PM and returned on at 3:13 PM. | A 080 | | |

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| A 080 | Continued From page 29<br><br>She provided a core certificate with the certification number of 171239970 issues .<br><br>Further record review of the employee file for the Administrator found the only evidence of training since was a 6 hour medication training on and a 1 hour first aid training on .<br><br>During further interview with the owner of the facility on at 3:15 AM, she stated the only training she had for the Administrator was in the two files she had provided.<br><br>A telephone conversation was held with the Administrator on at 11:40 AM. The Administrator was notified he was needed at the facility to help the surveyors obtain information. He stated he was at work and trying to get out and would be at the facility. He stated he was still the Administrator and that he was looking at getting a replacement. The Administrator was not at the facility during the survey from 9:40 AM until 4:25 PM. He was not able to provide additional information.<br><br>Class III | A 080 | | |
| A 083 | 59A-36.011(5) FAC Training - First Aid and .<br><br>(5) FIRST AID AND . ( ). 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.<br>(a) Documentation that the staff member possess | A 083 | | |

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| A 083 | Continued From page 30<br><br>current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement.<br>(b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on employee record review, review of the facility schedule, and staff interview, the facility failed to ensure one staff member working in the facility at all times was trained in First Aid for 1 of 2 sampled employees (Employee A) therefore putting the health and safety of the 6 residents that reside in the facility at risk.<br><br>The findings include:<br><br>On entrance to the facility onn at 9:45 AM, Employee A was observed working alone.<br><br>Record review for Employee A (hired ) found her first aid training expired on .<br><br>The findings were confirmed during an interview with Employee A on at 10:50 AM. She stated she did not have a current First Aid card. She confirmed she worked alone in the facility during the 8:00 AM to 8:00 PM shift. | A 083 | | |

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| A 083 | Continued From page 31<br>Photographic evidence obtained.<br><br>Class III | A 083 | | |
| A 084 | 59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt<br><br>59A-36.011<br>(6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria:<br>(a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance.<br>(b) The training must be provided by a registered | A 084 | | |

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| A 084 | Continued From page 32<br>nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to:<br>1. Read and understand a prescription label;<br>2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including:<br>a. Assist with oral dosage forms, [illegible] dosage forms, and [illegible] and dosage forms;<br>b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions;<br>c. Recognize the need to obtain clarification of an "as needed" prescription order;<br>d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders;<br>e. Complete a medication observation record;<br>f. Retrieve and store medication;<br>g. Recognize the general signs of adverse reactions to medications and report such reactions;<br>h. Assist residents with [illegible] syringes that are prefilled with the proper dosage by a pharmacist and [illegible] that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection;<br>i. Assist with [illegible];<br>j. Use a [illegible] to perform [illegible] testing;<br>k. Assist residents with [illegible] and continuous positive airway pressure (CPAP) devices, excluding the titration of the [illegible] | A 084 | | |

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| A 084 | Continued From page 33<br><br>levels;<br>l. Apply and remove stockings and hosiery;<br>m. Placement and removal of , bags, excluding the removal of the or manipulation of the site; and,<br>n. Measurement of , , rate, temperature, and , rate.<br>(c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online.<br>(d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n.<br><br>429.52<br>(6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training | A 084 | | |

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| A 084 | Continued From page 34<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, staff interview and record review, the facility failed to ensure 1 of 2 sampled employees providing assistance with self-administration of medication completed two hours of the required assistance with self-medication training annually.(Employee A)<br><br>The findings include:<br><br>An observation of Resident 6 was conducted at 11:26 am on . He was with Employee A, Caregiver, who was assisting him with the self-administration of his medication. Employee A retrieved a basket from the medication storage cabinet and brought it to Resident 6, who sat at the dining table. She prepared the monitoring device and after he used it, she retrieved Resident 6's , and announced he would receive 30 units of . She uncapped the needle and handed the , to the resident.<br><br>Record review for Employee A (hired ) found the most recent training in providing assistance with self-administered medications was a 6 hour course on .<br><br>The Owner was notified the employee file did not contain a more recent training. During an interview with the Owner on at 11:37 AM she stated, she called the provider who does the training for the facility to see if she could provide evidence of Employee A's training.<br><br>At the time of exit from the facility on at 4:25 PM the Owner did not have evidence of annual assistance with self-administration training for Employee A. The Administrator had not | A 084 | | |

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| A 084 | Continued From page 35<br><br>arrived at the facility by the time the team left to provide any additional information on Employee A's training.<br><br>Class III | A 084 | | |
| A 085 | 59A-36.011(7) FAC Training - Nutrition & Food Service<br><br>(7) NUTRITION AND FOOD SERVICE. The administrator or person designated by the administrator as responsible for the facility's food service and the day-to-day supervision of food service staff must obtain, annually, a minimum of 2 hours continuing education in topics pertinent to nutrition and food service in an assisted living facility. This requirement does not apply to administrators and designees who are exempt from training requirements under paragraph 59A-36.012(1)(b). A certified food manager, licensed dietician, registered dietary technician or health department sanitarian is qualified to train assisted living facility staff in nutrition and food service.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on employee record review and an interview with the owner, the facility failed to ensure the Administrator/food service designee for the facility obtained a minimum of 2 hour continuing education in food service and nutrition.<br><br>The findings include:<br><br>During an interview with the Owner of the facility on at 3:15 PM, she stated she and the Administrator were responsible for food service at the facility. She was asked for the Administrator's food service training. She stated | A 085 | | |

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| A 085 | Continued From page 36<br>the only training she had for the Administrator was in the two files she had provided.<br><br>Record review of the employee files for the Administrator revealed he was hired as the Administrator for the facility on . A review of both files provided by the Owner found no evidence of a two hour food service training.<br><br>At the time of the exit conference at 4:25 PM, the Owner did not have any additional information to provide and the Administrator had not arrived present to provide input.<br><br>Class III | A 085 | | |
| A 093 | 59A-36.012(2) FAC Food Service - Dietary Standards<br><br>(2) DIETARY STANDARDS.<br>(a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are incorporated by reference and available for review at: http://iom.edu/Activities/Nutrition/SummaryDRIs/~/media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%2014.pdf. Therapeutic diets must meet these nutritional standards to the extent possible.<br>(b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food | A 093 | | |

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| A 093 | Continued From page 37<br>habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes.<br>(c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet.<br>1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences.<br>2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents.<br>(d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months.<br>(e) Therapeutic diets must be prepared and served as ordered by the health care provider. | A 093 | | |

Agency for Health Care Administration

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| A 093 | Continued From page 38<br><br>1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility.<br>2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal.<br>(f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of [illegible] the time between meals.<br>(g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on [illegible].<br>(h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has [illegible] with residents to serve, must be on [illegible] at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must | A 093 | | |

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| LOVING ANGELS ASSISTED LIVING LLC | 9 RAMBLE WAY PALM COAST, FL 32164 |

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| A 093 | Continued From page 39<br><br>also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, staff interviews and a review of facility records, the facility failed to ensure menus used were reviewed annually by a licensed or registered dietitian, a licensed nutritionist, a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist. The facility failed to substitute menu items with items of comparable nutritional value, failed to note substitutions before or when the meal is served and to maintain substitutions on file for 6 months.<br><br>The findings include:<br><br>1. On entrance to the facility at 9:45 am on , the menu was observed posted on the wall in the kitchen. It was signed by the Registered Dietician on and was turned to week 2 of a 4 week menu cycle. Employee A, Caregiver, confirmed in an interview at 9:55 am on that this was the current menu she was going by. Photographic evidence was obtained.<br><br>During a tour of the facility at 10:00 am on , it was determined there were 6 residents residing in the home.<br><br>The menu revealed that lunch for the day of survey ( ) was beef stew, noodles, mixed | A 093 | | |

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| A 093 | Continued From page 40<br><br>vegetables, mixed salad and gelatin. Observation of the lunch meal at 12:00 pm on . . . . . revealed the residents were each served 2 to 3 large slices of pepperoni pizza and coffee and/or juice. No green salad or vegetable was served, nor was gelatin.<br><br>At 12:57 pm on . . . . . , Employee A was asked where she documented menu substitutions. She said "I just look at the menu. Today is Wednesday." The menu was reviewed with her and it called for beef stew today. She confirmed that and confirmed residents had pizza today. She was asked again for the substitution log but no log was produced.<br><br>In an interview with Employee D, Caregiver, 1:00 pm on , she stated she had been working on taking over the Administrator duties for about 2 months. She reviewed the menu. Employee D confirmed it had not been reviewed by the dietician annually, as required. She was asked for the substitution log. She said it was here somewhere, but could not produce any log by the end of the survey.<br><br>Class III | A 093 | | |
| A 152 | 59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other<br><br>(3) OTHER REQUIREMENTS.<br>(a) All facilities must:<br>1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.;<br>2. Be maintained free of hazards; and, | A 152 | | |

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| A 152 | Continued From page 41<br><br>3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order.<br>(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:<br>1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident,<br>2. A closet or wardrobe space for hanging clothes,<br>3. A dresser, or other furniture designed for storage of clothing or personal effects,<br>4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and,<br>5. A comfortable chair, if requested.<br>(c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency.<br>(d) Residents who use portable bedside commodes must be provided with privacy during use.<br>(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 .<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observations and interviews with staff and residents, the facility failed to ensure a safe living environment with readily accessible egress in the event of a fire or other emergency requiring evacuation. This placed all 6 residents at a risk in the event they needed to exit the facility | A 152 | | |

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| A 152 | Continued From page 42<br>immediately.<br><br>The findings include:<br><br>On entrance to the facility at 9:45 am on , the interior of the front door was observed to have a key-operated deadbolt lock. A key on a long red lanyard was observed hanging from the lock. A large "Exit" sign was posted above the front door, indicating it was an emergency exit. A plastic baby gate was observed hanging at - across the kitchen doorway. A sign on the gate instructed "STAFF ONLY, RESIDENTS ARE NOT ALLOWED." Photographs were obtained.<br><br>During a tour of the facility at 10:00 am on , it was determined there were 6 residents residing in the home. One Caregiver was on duty at that time.<br><br>At 10:25 am on , a resident stated the door was not opening. The Owner, who arrived after the survey commenced, then tried to open the door, with no success. She then removed the key from the front door and took it to the sliding glass door to attempt to unlock it. Observation of the door found a large "Exit" sign posted above, indicating it was also an emergency exit. The front door was checked at this time and was discovered to be locked.<br><br>At 11:10 am on , several residents gathered in the living room and were visiting with each other. The front door was checked at this | A 152 | | |

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| A 152 | Continued From page 43<br>time. It remained locked with no key in the deadbolt. Residents 2, 3, 4, 5, and 6 were asked which of them had a key to the front door. Resident 6 stated that the key was usually hanging on the wall in the kitchen from the long red cord. He did not have a personal key. Residents 2 and 4 also confirmed they did not have keys to the lock. Observation of the kitchen at this time found no key hanging anywhere.<br><br>Observations of the front door were conducted at 11:45 am, 2:35 pm, and 3:24 pm on . . . . . Each observation found the door remained locked, with no key in the deadbolt. There was no key hanging in the kitchen at any of the referenced times.<br><br>At 12:35 pm on , the door partially opened when pushed, but would not move further in it's track.<br><br>An interview was conducted with Employee D, Caregiver, at 3:30 pm on . She had arrived at the facility at 1:00 pm to assist with the survey. Employee D confirmed the front door was locked much of the time. She said sometimes it was unlocked and sometimes the key was left in the door, but the residents did not have their own key(s). Employee D confirmed the front door was a fire exit. She also confirmed the key was stored in the kitchen drawer. Employee D acknowledged the sign on the gate prohibited residents from entering the kitchen.<br><br>An interview was conducted with Employee A, Caregiver, at 3:20 pm on . She stated | A 152 | | |

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| A 152 | Continued From page 44<br><br>she kept the front door locked at all times when the residents were home. The residents did not have a key. Employee A said she kept the key in the drawer in the baker's rack in the kitchen. She was asked what would happen if a fire broke out and she was not able to safely get to the key. She stated she would have to go around the house. When reminded that if the door was locked from the inside and the key in the kitchen, she would not be able to open the front door from the outside. Employee A said she would have to try to open the window.<br><br>Class III | A 152 | | |
| A 160 | 59A-36.015(1) FAC Records - Facility<br><br>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.<br>(1) FACILITY RECORDS. Facility records must include:<br>(a) The facility's license displayed in a conspicuous and public place within the facility.<br>(b) An up-to-date admission and discharge log listing the names of all residents and each resident's:<br>1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident | A 160 | | |

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| A 160 | Continued From page 45<br>was admitted with a [illegible]; and,<br>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].<br>(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).<br>(d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in rule 59A-36.019, F.A.C., that must be readily available by facility staff.<br>(e) The facility's liability insurance policy required in rule 59A-36.013, F.A.C.<br>(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.<br>(g) The admission package presented to new or prospective residents (less the resident's contract) described in rule 59A-36.006, F.A.C.<br>(h) If the facility advertises that it provides special care for persons with 's or related [illegible], a copy of all such facility advertisements as required by section 429.177, F.S.<br>(i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in rule 59A-36.007, F.A.C.<br>(j) All food service records required in rule 59A-36.012, F.A.C., including menus planned | A 160 | | |

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| A 160 | Continued From page 46<br><br>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.<br>(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.<br>(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.<br>(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.<br>(n) The facility's resident elopement response policies and procedures.<br>(o) The facility's documented resident elopement response drills.<br>(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.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, record review, and interview, the facility failed to maintain an up-to-date admission and discharge log for 1 of 6 residents residing at the facility (Resident #4) and failed to maintain a comprehensive emergency management plan at the facility affecting the safety of 6 out of the 6 residents residing in the facility. | A 160 | | |

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| A 160 | Continued From page 47<br><br>The findings include:<br><br>1. During a tour of the facility on . . . . . at 10:00 AM six residents were observed living in the facility. A review of the facility's admission and discharge log found 5 residents were listed as still living in the facility. Resident 4's name was not on the log.<br><br>During an interview with Caregiver A on . . . . . at 12:50 PM, she was asked for Resident 4's record and when he was admitted to the facility. She pulled out the medication observation records for Resident 4 that showed he received medication at the facility beginning . During an interview with Resident 4 on . . . . . at 12:55 PM, he was asked when he was admitted to the facility. He stated about three months ago and he guessed around . . . . . .<br><br>2. During an interview with the Owner of the facility on at 10:13 AM, she was asked for a copy of the building's comprehensive emergency management plan (CEMP) and approval letter. She stated she did not have the CEMP approval letter or the CEMP at the facility.<br><br>Class III | A 160 | | |
| A 162 | 59A-36.015(3) FAC Records - Resident<br><br>(3) RESIDENT RECORDS. Resident records must be maintained on the premises and include:<br>(a) Resident demographic data as follows:<br>1. Name,<br>2. ,<br>3. Race, | A 162 | | |

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| A 162 | Continued From page 48<br>4. Date of birth,<br>5. Place of birth, if known,<br>6. Social security number,<br>7. Medicaid and/or Medicare number, or name of other health insurance . . ,<br>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,<br>9. Name, address, and telephone number of the health care provider and case manager, if applicable.<br>(b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C.<br>(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.<br>(d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable.<br>(e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C.<br>(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.<br>(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 such consent is not included in the resident's contract.<br>(h) For facilities that manage a pill organizer, assist with self-administration of medications or | A 162 | | |

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| A 162 | Continued From page 49<br>administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C.<br>(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.<br>(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.<br>(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.<br>(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.<br>(m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable.<br>(n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C.<br>(o) The resident's , DH Form 1896, if applicable. | A 162 | | |

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| A 162 | Continued From page 50<br><br>(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:<br>1. A log listing the names of residents participating in this arrangement,<br>2. The resident demographic data required in this paragraph,<br>3. The health assessment described in rule 59A-36.006, F.A.C.,<br>4. The resident's contract described in rule 59A-36.018, F.A.C.; and,<br>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.<br>(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.<br>(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.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, review of resident records and interview with staff, the facility failed to maintain complete and accurate resident health assessments (AHCA form 1823s) for 3 of 3 | A 162 | | |

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|---|---|---|---|
| | AL11968482 | A. BUILDING: _____ B. WING _____ | 10/27/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LOVING ANGELS ASSISTED LIVING LLC | 9 RAMBLE WAY PALM COAST, FL 32164 |

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| A 162 | Continued From page 51<br><br>residents whose records were reviewed (Residents 2, 3 and 6), and failed to obtain ( ), for 1 of 2 residents reviewed. (Resident # 3) out of a total of 6 residents in the sample.<br><br>The findings include:<br><br>1. An observation of Resident 6 was conducted at 11:26 am on . He was with Employee A, Caregiver, who was assisting him with the self-administration of his medication. Employee A retrieved a basket from the medication storage cabinet and brought it to Resident 6, who sat at the dining table. After inserting a lancet into a spring loaded lancing device (a device used by to penetrate the skin in order to obtain a sample for testing), she handed the device to the resident. He placed the device on the tip of his left pointer , deployed the lancet, and placed a drop of his onto the wicking strip on a meter. Employee A retrieved Resident 6's , and announced he would receive 30 units of . She uncapped the needle and handed the to the resident. Resident 6 dialed the pen to 30 units, which was confirmed visually by this writer. Without assistance, Resident 6 injected the into the left side of his abdomen.<br><br>Record review for Resident 6 revealed an AHCA form 1823 (Resident Health Assessment) dated . Resident 6 was noted as , requiring frequent reminders. He required assistance with activities of daily living and daily oversight for his wellbeing. Section C. of the | A 162 | | |

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| A 162 | Continued From page 52<br><br>assessment stated he required 24 hour nursing care and that his needs could not be met in an assisted living facility. Page 4. noted Resident 6 needed to have his medications administered for him. Page 5. of the assessment, which is intended to be completed by the Administrator to list the services provided by the facility, was missing altogether. Further review of the record confirmed Resident 6 had a diagnosis of . Photographic evidence was obtained.<br><br>An interview was conducted with the owner at 1:54 pm on . She reviewed Resident 6's health assessment and stated maybe she took out page 5. to have Employee D sign it. She acknowledged the Administrator was supposed to sign it. She also acknowledged the assessment indicated Resident 6 required medication administration but was observed to self-administer his own , and that he was noted to need 24-hour nursing services and was not appropriate for an assisted living facility.<br><br>2. Record review for Resident 2 revealed an AHCA 1823 dated . Resident 2 was noted to be slow and resentful, with mental related to . The 5-page form was incomplete, as it only contained pages 1 and 4. The form omitted the sections asking the following: Her elopement risk status; the level of assistance she needed with activities of daily living; dietary instructions; communicable status; status; whether or not she presented a danger to herself or others; whether or not she required 24-hour nursing or care; whether or not her needs could be met in an assisted living facility; her ability to perform self-care and independent living tasks; and, her | A 162 | | |

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| A 162 | Continued From page 53<br>need for general oversight. The last page, which is intended to be completed by the Administrator to list services the facility would provide this resident, was missing.<br><br>An interview was conducted with Employee D, Caregiver, at 2:15 pm. She reviewed the assessment and confirmed the missing pages and required information.<br><br>2. Record review of the AHCA 1823 Resident Health Assessment for Resident #3 based on a evaluation found Page 5 was missing. The last page, which is intended to be completed by the Administrator to list services the facility would provide this resident, was missing.<br><br>The findings were confirmed during an interview with the Owner of the facility on at 1:55 PM. She stated she may have taken it out of the resident record so the Administrator could sign it.<br><br>3. Record review for Resident #3 revealed he was admitted to the facility on and signed a paper on that he had a . (Photographic evidence obtained.) Further record review for Resident #3 found no evidence of a in his resident file.<br><br>Caregiver A was asked for the for Resident #3 on at 12:18 PM. She was observed going into the garage. When she returned from the garage at 12:20 PM she was | A 162 | | |

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| A 162 | Continued From page 54<br><br>asked if the facility had a book. She stated she did not have anything to provide.<br><br>The Owner came to the facility on at 1:00 PM. She was asked for the info for Resident #3. She stated he did not have anything and that he was full code. She was shown the paper the resident's POA signed stating the resident had a . She stated she spoke to the POA for Resident #3. She stated she did not know when and the POA did not have any paperwork provide.<br><br>Class III | A 162 | | |

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| CZ816 | 408.809(2a-c) 435.05(2) 59A-35.090(2d-3c Background Screening-Compliance Attestation<br><br>408.809 Background screening; prohibited offenses.-<br>(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 ␣␣␣. The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or | CZ816 | | |

AHCA Form 3020-0001

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

Agency for Health Care Administration

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| CZ816 | Continued From page 1<br><br>professional licensure requirements of 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:<br>(a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section;<br>(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<br>(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.<br><br>435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers:<br>(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.<br><br>59A-35.090 Background Screening.<br>(2) Processing Screening Requests, Required Documents and Fees.<br>(d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, , herein incorporated by reference, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-09106, and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Service | CZ816 | | |

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| CZ816 | Continued From page 2<br><br>s/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.<br>(e) An administrator or chief financial officer must be screened and qualified prior to to the position.<br>(3) Results of Screening and Notification.<br>(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.<br>(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.<br>(c) The eligibility results of employee screening and the signed Attestation referenced in subsection 59A-35.090(2), F.A.C., must be in the employee's personnel file, maintained by the provider.<br><br>This Statute or Rule is not met as evidenced by: | CZ816 | | |

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| CZ816 | Continued From page 3<br><br>Based on record review and an interview with the Owner, the facility failed to ensure an Attestation of Compliance with Background Screening Requirements, was obtained and kept in the employee file for 2 of 3 employees reviewed. (Employees B and C)<br><br>The findings include:<br><br>Record review for Employee B (hired ) found no evidence of an Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008 in the employee record.<br><br>Record review for the Administrator (hired ) found no evidence of an Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008 in the employee record.<br><br>The Owner was notified of the missing information. The Owner left the facility around 11:30 AM and 2:30 PM to look for additional employee records and was not able to provide the attestations. At the time of the exit conference at 4:25 PM on , the Owner did not have any additional information to provide.<br><br>Unclassified | CZ816 | | |
| CZ830 | 408.821 FS Emergency Management Planning<br><br>408.821 Emergency management planning; emergency operations; inactive license.-<br>(1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for | CZ830 | | |

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| CZ830 | Continued From page 4<br><br>emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows:<br>(a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan.<br>(b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan.<br>(c) Submit necessary plan revisions within 30 days after notification that plan revisions are required.<br>(d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health.<br>(2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers.<br>(3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider:<br>1. Suffered damage to its operation during the state of emergency.<br>2. Is currently licensed. | CZ830 | | |

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| CZ830 | Continued From page 5<br><br>3. Does not have a provisional license.<br>4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months.<br>(b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes.<br>(4) The agency may adopt rules relating to emergency management planning, communications, and operations. Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations.<br><br>This Statute or Rule is not met as evidenced by: | CZ830 | | |

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| CZ830 | Continued From page 6<br><br>Based on an interview with the owner of the facility and a review of the Agency for Health Care Administration Emergency Status System (ESS), the facility failed to ensure the safety of its 6 current residents, by failing to report the following information using the online database (ESS): facility census, available beds, inventory, needs, and other related information for Novel Coronavirus (COVID-19) daily by 10:00 AM, pursuant to Executive Order 20-51, and at the direction of the State Surgeon General, for 8 of 28 most recent days reviewed.<br><br>The findings include:<br>Record review of the ESS submissions from through revealed the facility failed to make submissions on [redacted].<br><br>During an interview with the owner on [redacted] at 3:14 PM, she stated she updates ESS. She stated does the updates for the facility along with her other facilities. She stated sometimes does not save the information or go [redacted] to check to see the information was updated. She was given the dates of the missing submissions and she stated she was aware they were missing.<br><br>Pursuant to the Governor's Executive Order 20-51, and at the direction of the State Surgeon General regarding Novel Coronavirus (COVID-19), the Agency for Health Care Administration opened the event "COVID-19 Monitoring" in the Emergency Status System to monitor assisted living facilities census, inventory, needs and other related information statewide. All assisted living facilities were required to report current resident census and available beds in their facilities by 10:00 AM and answer additional | CZ830 | | |

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| CZ830 | Continued From page 7<br>questions related to the facility status and COVID-19. Notification to facilities was dated<br>Class | CZ830 | | |