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
	AL11967240	A. BUILDING: _____ B. WING _____	11/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TORIA'S ASSISTED LIVING FACILITY II	613 FOREST HILLS BRANDON, FL 33510

(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
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12(2) Care Provider Background Screening Clearinghouse.- (b) Until such time as the [illegible] are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [illegible] submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; [illegible]; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to maintain an up to date Background Screening Employee Roster (BGSER). Findings Included: During observation conducted on [illegible] at 06:50am, Staff A was observed passing	CZ814		

AHCA Form 3020-0001

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

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CZ814	Continued From page 1 medications to the resident in the facility. A review of the Facility's BGSER, conducted on , revealed Staff A was not listed on the BGSER. Staff A was hired on . Staff D, Staff E, and Staff F continued to be listed as a current employee on the BGSER. A review of employee records for Staff A, Staff D, and Staff E, conducted on , revealed that the Facility's BGSER was not up to date. Staff A was hired on and was a current employee at the Facility. Staff D was hired on and was no longer an employee at the Facility. Staff E was hired on and no longer worked at the Facility. Staff F was hired on and no longer worked at the Facility. The termination dates of Staff D, Staff E, and Staff F were not provided. During an interview with the Resident Program Manager, conducted on at 10:52am, the Program Manager stated that here were only three employees at the Facility. The Program Manager stated that Staff D, Staff E, and Staff F no longer worked at the Facility. The Program Manager stated that Staff D no longer worked for the company and Staff E and Staff F worked at another of the company's communities. Unclassified	CZ814		
CZ816	408.809(2a-c) 435.05(2) 59A-35.090(2d-3c Background Screening-Compliance Attestation 408.809 Background screening; prohibited offenses.- (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity	CZ816		

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CZ816	Continued From page 2	CZ816		

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 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,

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CZ816	Continued From page 3 provided that: (a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section; (b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and (c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency. 435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers: (2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if . . . . . for any of the disqualifying offenses while employed by the employer. 59A-35.090 Background Screening. (2) Processing Screening Requests, Required Documents and Fees. (d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, . . . , . . . , herein incorporated by reference, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-09106, and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Regulations_Forms.shtml. This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for	CZ816		

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CZ816	Continued From page 4 more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if . . . . . for any disqualifying offense. (e) An administrator or chief financial officer must be screened and qualified prior to , , to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the . . . report and court disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with section 435.06(3), F.S. (c) The eligibility results of employee screening and the signed Attestation referenced in subsection 59A-35.090(2), F.A.C., must be in the employee's personnel file, maintained by the provider. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to ensure that an Attestation of Compliance was signed and included in two employee records (Administrator and Staff B) of four sampled employee records.	CZ816		

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CZ816	Continued From page 5 Findings Included: A record review for the Administrator and Staff B, conducted on [redacted], revealed that the Administrator and Staff B did not have a signed Attestation of Compliance in their employee records. The Administrator was hired on [redacted]. Staff B was hired on [redacted]. During an interview with the Resident Program Manager, conducted on [redacted] at 12:15pm, the Resident Program Manager agreed that there was no signed Attestation of Compliance in the Administrator's or Staff B's employee records. Unclassified	CZ816		

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A 000	Initial Comments A Re-licensure Survey, a Complaint Investigation (Complaint Number: 2020016479), a COVID-19 Control Monitoring, and a Generator Monitoring were conducted at Toria's Assisted Living Facility II on . Deficiencies were identified at the time of survey.	A 000		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, including an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer, from where it is stored, and bringing it to the resident. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage.	A 052		

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A 052	Continued From page 1 (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (h) Using a to perform - level checks. (i) Assisting with putting on and taking off stockings. (j) Assisting with applying and removing an but not with titrating the prescribed settings. (k) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device. (l) Assisting with measuring vital signs. (m) Assisting with bags. (4) Assistance with self-administration does not include: (a) Mixing, , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with	A 052		

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A 052	Continued From page 2 prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in section 429.256, F.S. and this rule. (b) In addition to the specifications of section 429.256(3), F.S., assistance with self-administration of medication includes, in the presence of the resident, reading the medication label aloud and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups,	A 052		

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A 052	Continued From page 3	A 052		

and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container.
(d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record.
(e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed:
1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility,
2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record,
3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or
4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging.
(f) Assistance with self-administration of medication does not include the activities detailed in section 429.256(4), F.S.
1. As used in section 429.256(4)(g), F.S., the term "competent resident" means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication.

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A 052	Continued From page 4 2. As used in section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (g) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure proper assistance with self-administration of medications according to the required steps in 429.256 Florida Statutes and failed to follow control standards while assisting with medications for five Residents (#1, #2, #3, #4, and #5) of five sampled residents that required assistance with self-administration of medication. Findings Included: During an observation of the medication pass with Staff A for Residents #1, #2, #3, #4, and #5, Staff A did not ensure proper assistance with self-administration of medications. At 07:00am, Staff A assisted Resident #5 with the prescribed medications 20mg, 1mg, , 5mg, , 5mg, 100mg, and , 250mg at the kitchen counter. Resident #5's Medication Observation Records (MORs) were not present. Staff A did not compare the medication labels to the MORs. Staff A did not read the medication name and dose to Resident #5. Staff A did not observe Resident #5 take and swallow the medication. Resident #5 dropped one pill on the floor and had Staff A help her find the tablet. Staff A pointed at	A 052		

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A 052	Continued From page 5 the pill and Resident #5 picked the pill up off the floor. Staff A did not offer to replace the pill and Resident #5 took the pill. Staff A took Resident #5's pill packs to the medication closet and retrieved four plastic cups with pills in them. Staff A placed one cup on the kitchen counter and three cups on the kitchen table. The cups had no labels on them to identify what the pills were inside the cups or who the medications belonged to. Staff A left the area to tell Residents #1, #2, #3, and #4 to come to the dining room. The residents came into the dining room and picked up the cups of medications. Staff A did not tell Residents #1, #2, #3, or #4 the medications that they were receiving. At 07:10am, Resident #5 dropped another pill on the floor and had Staff A help find the pill. Resident #5 found the pill and took the pill. Staff A did not offer to replace the medication. Staff A did not wash or sanitize her before, during, or after the medication pass. Staff A went into the kitchen after the medication pass and continued prepping the breakfast meal. During an attempt to review the Facility's policy and procedures regarding control practices, conducted on at 11:20am, the Facility's policy and procedures regarding control practices were not provided. A record review for Staff A, conducted on , revealed that Staff A did not have 6-hours of assistance with self-administration of medication training. Staff A was hired on as a Medication Technician and Resident Care Aide. During an interview with the Resident Program Manager, conducted on at 12:15pm, the Resident Program Manager agreed that unlicensed Medication Technicians were	A 052		

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A 052	Continued From page 6 supposed to compare medication labels with MORs, pop pills from medication packs in front of residents, and read the name of the medication and dose of the medication to residents. The Program Manager was unable to provide the Facility's policy and procedures regarding [illegible] control practices. Class III	A 052		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known [illegible] the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors.	A 054		

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A 054	Continued From page 7 (c) For medications that serve as chemical , the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to update Medication Observation Records (MORs) immediately each time medications were offered to five Residents (#1, #2, #3, #4, and #5) of five sampled residents. Findings Included: A MORs review for Resident #1, conducted on , revealed that Resident #1 had medications not signed as given to Resident #1. Resident #1's prescribed medications , 5mg and 850mg were not documented as given to the resident on and at 08:00am (Photographic Evidence Obtained). A MORs review for Resident #2, conducted on , revealed that Resident #2 had medications not signed as given to Resident #2. Resident #2's prescribed medications , 5mg and , 300mg were not documented as given to the resident on and at 08:00am (Photographic Evidence Obtained). A MORs review for Resident #3, conducted on , revealed that Resident #3 had medications not signed as given to Resident #3. Resident #3's prescribed medications , 2mg and 20mg were not documented as given to the resident on and at 08:00am	A 054		

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A 054	Continued From page 8 (Photographic Evidence Obtained). A MORs review for Resident #4, conducted on , revealed that Resident #4 had medications not signed as given to Resident #4. Resident #4's prescribed medications , 200mg and 500mg were not documented as given to the resident on and at 08:00am (Photographic Evidence Obtained). A MORs review for Resident #5, conducted on , revealed that Resident #5 had medications not signed as given to Resident #5. Resident #5's prescribed medications , 10mg and , 250mg were not documented as given to the resident on and at 08:00am. Resident #5's prescribed medication Basaglar 100units/ml injection was not documented as given on at 08:00pm (Photographic Evidence Obtained). During an interview with the Resident Program Manager, conducted on at 12:15pm, the Resident Program Manager agreed that Resident #1, #2, #3, #4, and #5's MORs had medications not documented as given to the residents. Class III	A 054		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible,	A 055		

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A 055	Continued From page 9 residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the	A 055		

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A 055	Continued From page 10 refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit	A 055		

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A 055	Continued From page 11 issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and interview, the Facility failed to keep centrally stored medication in a locked cabinet or cart secured at all times. Findings Included: Observations conducted on at 07:00am, 07:10am, and 07:36am revealed the medication closet door was observed as open with the keys in the key lock. There was no staff present at these times. Residents were observed in and around the area of the medication closet. During an interview with the Resident Program Manager, conducted on at 12:15pm, the Resident Program Manager agreed that medication was to be locked and secured at all times. Class III	A 055		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another	A 078		

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A 078	Continued From page 12 when the facility is under the same management or ownership. 1. Evidence of a negative . . . . . examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual . . . . . examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . . . . . . 2. If any staff member has, or is suspected of having, a communicable . . . . . , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility . . . . . to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility	A 078		

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A 078	Continued From page 13 and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff . . . . . by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain evidence of a negative ( ) examination annually as required and a one-time statement that the employee was free from communicable from a health care provider for four employees (Administrator, Staff A, B, and C) of four sampled employees. Findings Included: An employee record review for the Administrator, conducted on , revealed that the Administrator did not have evidence that the employee was free from or a one-time statement that the employee was free from communicable from a health care provider in the employee's record. The Administrator was hired on . An employee record review for Staff A, conducted on . . . . . , revealed that Staff A did not have evidence that the employee was free from or a one-time statement that the employee was free from communicable from a health care	A 078		

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A 078	Continued From page 14 provider in the employee's record. Staff A was hired on . An employee record review for Staff B, conducted on , revealed that Staff B did not have evidence that the employee was free from annually as required from a health care provider in the employee's record. Staff B had a , that showed that the employee was free from on but there were no statements from a health care provider since that date that the employee was free from . Staff B was hired on . An employee record review for Staff C, conducted on , revealed that Staff C did not have evidence that the employee was free from annually as required from a health care provider in the employee's record. Staff C had evidence that the employee was free from on but there were no statements from a health care provider since that date that the employee was free from . Staff C was hired on . During an interview with the Resident Program Manager, conducted on at 12:15pm, the Resident Program Manager agreed that the Administrator and Staff A did not have evidence that the employees were free from or a one-time statement from that the employees were free from communicable . The Resident Program Manager agreed that Staff B and C did not have evidence that they were free from from a health care provider annually as required. Class III Class III	A 078		

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A 080	Continued From page 15	A 080		
A 080 SS=D	429.52( ) FS; 59A-36.011(1) FAC Training - Core & Competency Test 429.52 (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. (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: (a) State law and rules relating to assisted living facilities. (b) Resident rights and identifying and reporting , neglect, and . (c) Special needs of elderly persons, persons with mental illness, and persons with , and how to meet those needs. (d) Nutrition and food service, including acceptable sanitation practices for preparing, storing, and serving food. (e) Medication management, recordkeeping, and proper techniques for assisting residents with self-administered medication. (f) Fire safety requirements, including fire evacuation drill procedures and other emergency procedures. (g) Care of persons with 's and related . 59A-36.011	A 080		

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A 080	Continued From page 16 (1) ASSISTED LIVING FACILITY CORE TRAINING REQUIREMENTS AND COMPETENCY TEST. (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. (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. (c) Administrators and managers shall participate in 12 hours of continuing education in topics related to assisted living every 2 years. (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: 1. Retake the assisted living facility core training; and, 2. Retake and pass the competency test.	A 080		

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A 080	Continued From page 17 (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. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to provide evidence that the Administrator completed core the core training requirements and failed to provide evidence that the Administration completed twelve hours of continuing education every two years as required. Findings Included: An employee record review for the Administrator, conducted on , revealed that there was no core training certificate in the Administrator's record. There was no evidence in the Administrator's record that she had completed twelve hours of continuing education every two years as required. During an interview with the Resident Program Manager, conducted on , the Resident Program Manager agreed that the Administrator's employee record did not include evidence that the Administrator completed core training or twelve hours of continuing education every two years as required. Class III	A 080		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service	A 081		

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A 081	Continued From page 18 429.52(1) (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in in-service training relevant to their job duties as specified by agency rule of the agency. Topics covered during the preservice orientation are not required to be repeated during in-service training. A single certificate of completion that covers all required in-service training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record.	A 081		

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A 081	Continued From page 19 (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in [illegible] control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its [illegible] control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to [illegible] borne [illegible], may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident [illegible],	A 081		

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A 081	Continued From page 20 neglect, and , ... The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to provide direct care staff with the required in-service trainings for three employees (Staff A, B, and C) of three sampled employees. Findings Included: An employee record review for Staff A, conducted on , revealed that Staff A did not have	A 081		

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A 081	Continued From page 21 evidence that the employee received a two-hour Pre-service Orientation or a one-hour Control Trainings prior to providing direct care to residents. Staff A did not have evidence that the employee received one-hour of Reporting Adverse Incidents, a one-hour of Emergency Procedures, a one-hour Resident Right and Recognizing and Reporting , Neglect, and , , a three-hours of Activities of Daily Living and Behavioral Needs, a one-hour of Safe Food Handling, or a one-hour of Elopement Response Trainings within thirty days of hire. Staff A was hired on . An employee record review for Staff B, conducted on , revealed that Staff B did not have evidence that the employee received a one-hour Control Training prior to providing direct care to residents. Staff B did not have evidence that the employee received one-hour of Reporting Adverse Incidents, a one-hour of Emergency Procedures, a one-hour Resident Right and Recognizing and Reporting , Neglect, and , , a three-hours of Activities of Daily Living and Behavioral Needs, a one-hour of Safe Food Handling, or a one-hour of Elopement Response Trainings within thirty days of hire. Staff B was hired on . An employee record review for Staff C, conducted on , revealed that Staff C did not have evidence that the employee received a one-hour Control Training prior to providing direct care to residents. Staff C did not have evidence that the employee received one-hour of Reporting Adverse Incidents, a one-hour of Emergency Procedures, a one-hour Resident Right and Recognizing and Reporting , Neglect, and , , a three-hours of Activities of Daily Living and Behavioral Needs, a one-hour of Safe	A 081		

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	AL11967240	A. BUILDING: _____ B. WING _____	11/09/2020

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A 081	Continued From page 22 Food Handling, or a one-hour of Elopement Response Trainings within thirty days of hire. Staff C was hired on [redacted]. During an interview with the Resident Program Manager, conducted on [redacted] at 12:15pm, the Resident Program Manager agreed that there was no evidence that Staff A, B, and C completed the required trainings in their employee records. Class III	A 081		
A 082 SS=D	59A-36.011(4) FAC Training - [redacted] (4) [redacted]. Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on and , including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to ensure that employees had the required one-time education course on [redacted] Training for three employees (Administrator and Staff A and C) of four sampled employees within thirty-days of employment. Findings Included:	A 082		

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A 082	Continued From page 23 A record review for the Administrator, conducted on . . . . . , revealed that the Administrator did not have evidence that the employee had completed the required one-time education on / training in the employee's record. The Administrator did not have evidence that the employee completed the / training with core training. The Administrator was hired on . A record review for Staff A, conducted on . . . . . , revealed that there was no evidence in Staff A's employee record that the employee had completed the required one-time education on / training within thirty days of employment. Staff A was hired on . . . . . . A record review for Staff C, conducted on , revealed that there was no evidence in Staff C's employee record that the employee had completed the required one-time education on / . . training within thirty days of employment. Staff C was hired on . During an interview with the Resident Program Manager, conducted on . . . . . , the Resident Program Manager agreed that there was no evidence that the Administrator, Staff A, and Staff C had completed the one-time education course on / . . . training within thirty days of hire. Class III	A 082		
A 084 SS=D	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011 (6) ASSISTANCE WITH THE	A 084		

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A 084	Continued From page 24 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: (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. (b) The training must be provided by a registered 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: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, . , . . dosage	A 084		

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A 084	Continued From page 25 forms, and and dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; 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; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with syringes that are prefilled with the proper dosage by a pharmacist and , 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; i. Assist with ; j. Use a to perform testing; k. Assist residents with and continuous positive airway pressure (CPAP) devices, excluding the titration of the levels; l. Apply and remove stockings and hosiery; m. Placement and removal of , bags, excluding the removal of the or manipulation of the site; and, n. Measurement of , rate, temperature, and , rate. (c) Unlicensed persons, as defined in section	A 084		

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A 084	Continued From page 26 429.256(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. (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. 429.52 (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 This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the Facility failed ensure that employees assisting residents with medications had the required Assistance with Self-Administration of Medications Training prior to assisting residents with medications for three unlicensed Medication Technicians (Staff A, B, and C) of three sampled employees.	A 084		

Agency for Health Care Administration

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A 084	Continued From page 27 Findings Included: During an observation of the medication pass with Staff A, conducted on at 07:00am, Staff A did not follow the steps required to ensure proper assistance with self-administration of medications. Staff A did not follow proper control standards while assisting residents with medications. An employee record review for Staff A, conducted on , revealed that Staff A had a six-hour medication assistance certificate for Adult Persons with dated and not a six-hour assistance with self-administration for assisted living facilities. An employee record review for Staff B, conducted on , revealed that Staff B had a six-hour medication assistance certificate for assisted living facilities dated . There was no evidence in in Staff B's record that the employee attended a two-hour update annually as required. An employee record review for Staff C, conducted on , revealed that Staff C had a six-hour medication assistance certificate for assisted living facilities dated . There was no evidence in in Staff C's record that the employee attended a two-hour update annually as required. During an interview with the Resident Program Manager, conducted on at 12:15pm, the Resident Program Manager agreed that Staff A did not have a six-hour assistance with self-administration training for assisted living facilities. The Resident Program Manager agreed	A 084		

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A 084	Continued From page 28 that Staff B and C did not have a two-hour training update for assistance with self-administration of medications annually as required. Class III	A 084		
A 090 SS=D	59A-36.011(11) FAC Training - (11) [redacted] TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding [redacted]. (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding [redacted] within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to provide the one-hour required training regarding the Facility's policy and procedures for [redacted] within 30-days of hire for four employees (Administrator and Staff A, B, and C) of four sampled employees. Findings Included: During an interview with Staff A, conducted on [redacted] at 07:55am, Staff A was unable to	A 090		

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A 090	Continued From page 29 answer the question, "what is a ?". Staff A asked, "what do you mean?" and "I don't know what that is". During an interview with Staff B, conducted on at 10:09am, Staff B was unsure what meant and was unable to answer the question, "what is a ?". A record review for the Administrator, conducted on , revealed that the Administrator did not have evidence that the employee had completed the required one-hour training. The Administrator did not have evidence that the employee completed the training with core training. The Administrator was hired on . A record review for Staff A, conducted on , revealed that there was no evidence in Staff A's employee record that the employee had completed a one-hour required training for the Facility's policy and procedures for within 30-days of employment. Staff A was hired on . A record review for Staff B, conducted on , revealed that there was no evidence in Staff B's employee record that the employee had completed a one-hour required training for the Facility's policy and procedures for within 30-days of employment. Staff B was hired on . A record review for Staff C, conducted on , revealed that there was no evidence in Staff C's employee record that the employee had completed a one-hour required training for the Facility's policy and procedures for within 30-days of employment. Staff C was hired	A 090		

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A 090	Continued From page 30 on . . . . . . During an interview with the Resident Program Manager, conducted on at 12:15pm, the Resident Program Manager agreed that there was no evidence that the Administration and Staff A, B, and C had completed the required one-hour training related to the Facility's policy and procedures for . . . within thirty-days of employment. Class III	A 090		
A 092 SS=D	59A-36.012(1) FAC Food Service - General Responsibilities (1) GENERAL RESPONSIBILITIES. When food service is provided by the facility, the administrator, or an individual designated in writing by the administrator, must be responsible for total food services and the day-to-day supervision of food services staff. In addition, the following requirements apply: (a) If the designee is an individual who has not completed an approved assisted living facility core training course, such individual must complete the food and nutrition services module of the core training course before assuming responsibility for the facility's food service. The designee is not subject to the 1 hour in-service training in safe food handling practices. (b) If the designee is a certified food manager, certified dietary manager, registered or licensed dietitian, dietetic registered technician, or health department sanitarian, the designee is exempt from the requirement to complete the food and nutrition services module of the core training course before assuming responsibility for the facility's food service as required in paragraph (1)	A 092		

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A 092	Continued From page 31 (a) of this rule. (c) An administrator or designee must perform his or her duties in a safe and sanitary manner. (d) An administrator or designee must provide regular meals that meet the nutritional needs of residents, and therapeutic diets as ordered by the resident's health care provider for residents who require special diets. (e) An administrator or designee must comply with the food service continuing education requirements specified in rule 59A-36.011, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to have an individual designated in writing by the Administrator for responsibility for total food services and the day to day supervision of food services. Furthermore, the Facility failed to adhere to the educational requirements and continuing education requirements pursuant to Rule 59A-36.011, Florida Administrative Code. Findings Included: During an interview with Resident #5, conducted on at 07:49am, Resident #5 sated that the meals were repetitive. It was the same thing over and over. Resident #5 sated that one day, the Facility had no food in the house and had to serve ice cream for lunch. During an interview with Resident #1, conducted on at 07:58am, Resident #1 stated that the Facility did not follow their posted menu and there was not much variety of foods. During an interview with Resident #1's family member, conducted on at 11:31am, the family member stated that Resident #1 had complained that the Facility had been out of food	A 092		

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A 092	Continued From page 32 and Resident #1 would use her personal credit card to purchase food. During a record review attempt for the food service designee, conducted on . . . . . , no record or designation was provided. Employee record reviews for the Administrator and Staff A, B, and C, conducted on . . . . . , revealed that the employee records did not have evidence that the Administrator or Staff A, B, and C had the required training or continuing education training as a food service designee. During an interview with the Resident Program Manager, conducted on at 12:15pm, the Resident Program Manager agreed that there was no evidence that the Facility had an individual designated in writing by the Administrator that had responsibility for total food services and day to day supervision of food services. The Resident Program Manager agreed that the Administrator and Staff A, B, and C did not have evidence that the employees had the required training or continuing education training as a food service designee. Class III	A 092		
A 093 SS=D	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (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	A 093		

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A 093	Continued From page 33 =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. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food 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. (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. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the	A 093		

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A 093	Continued From page 34 seasonal availability of fresh produce or the preferences of the residents. (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. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 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. 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. (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 _____ the time between meals. (g) Food must be served attractively at safe and	A 093		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 093	Continued From page 35 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 . . . . (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 . . 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 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. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the Facility failed to have a three-day supply of nonperishable foods and a sufficient supply of water for drinking and food preparation in the event of an emergency for a census of five in-house residents. Findings Included: A review of the Admission and Discharge Log, conducted on , revealed that there were five residents residing in the Facility on the day of survey. During an observation of the three-day emergency supply of nonperishable foods and water, conducted on at 11:10am, the food pantries shown to Surveyor was the general supply of food for day to day food service operation. There was no supply of food or water for three-days of meals in the event of an	A 093		

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	AL11967240	A. BUILDING: _____ B. WING _____	11/09/2020

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A 093	Continued From page 36 emergency. During an interview with the Resident Program Manager, conducted on at 12:15pm, the Resident Program Manager agreed that there the Facility did not maintain a supply of nonperishable food and water for three days in the event of an emergency. Class III	A 093		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable [illegible] to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and,	A 152		

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A 152	Continued From page 37 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain a safe and decent living environment by not providing a homelike environment free from rodents and failing to provide building repairs as needed. Findings Included: Observations conducted on beginning at 6:45am, revealed that the facility had an ongoing rat infestation, did not provide building repairs as needed, and had safety hazards. At 6:46am, there was a broken glass tabletop cover and Staff A stated, "be careful" and pointed at the broken glass on top of a wood table in the main entry area (Photographic Evidence Obtained). There were nine light bulbs in Resident #5's bathroom that were burnt out. There were towels rolled-up in each resident's doorway/entry into their rooms. At 8:25am, the bathroom next to the television room had two burnt out light bulbs, the shower was broken, the water did not get warm, and the water pressure was low. The lighting throughout the facility was dim. At 11:00am, the yard was observed with debris, blocks piled up, blocks in the walkway, bags of	A 152		

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A 152	Continued From page 38 leaves, in the front, side, and . . . yards. The walkway from the driveway had a hole in it. There was an outdoor sink/wash tube that was broken. The generator had a dent to the top and front of the generator sitting on a broken slab. There was a wood board placed as a ramp to the side door that was rotting (Photographic Evidence Obtained). During an interview with Resident #5, conducted on at 07:49am, Resident #5 stated that the facility had a rat problem and that the rolled-up towels in room entryways were to prevent the rats from getting into resident rooms. Resident #5 showed Surveyor her bathroom and there was a hole in the bathroom wall (Photographic Evidence Obtained). Resident #5 stated that the hole was where the rats come and go from. During an interview with Resident #1, conducted on . . . . . at 07:58am, Resident #1 stated that the facility had a very bad roach infestation and currently had an ongoing rat infestation. Resident #1 stated that the facility did not provide repairs as needed and that the facility's bathrooms had broken shower heads and no water pressure. During an interview with Staff A, conducted on . . . . . at 07:55am, Staff A stated that the facility had an ongoing rat problem that had been ongoing since the employee started working at the facility in . During an interview with the Administrator, conducted on at 08:40am, the Administrator stated that the Facility did not have	A 152		

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A 152	Continued From page 39 pest control contract with any company. During a record review for pest control, conducted on , a local pest control company made one visit to the Facility on for the visit on to place rodent traps around the Facility. There were no previous pest control prevention and treatment prior to . . . . . There were no follow up inspections or treatments scheduled. The pest control company's visit report stated that there was live activity in the living area, kitchen, and living room and for the Facility to schedule a three day follow up. A review of the local health department's inspection report dated , conducted on , the local health department noted two violations. The first violation was that "hot water shall be easily accessible where food is prepared and where utensils are washed". The second violation was a repeated violation for the lack of lighting in the Facility. During an interview with the Resident Program Manager, conducted on at 10:52am, the Resident Program Manager stated that Staff G provided maintenance to all the company's facilities and that the facility did not have their own maintenance person. At 12:15pm, the Resident Program Manager agreed that the facility did not provide repairs to broken items in and around the Facility. The Resident Program Manager agreed that the facility had an ongoing rat infestation. The Resident Program Manager agreed that the rolled-up towels in room entryways, blocked the walkway and the holes in the sidewalk were trip/ hazards. The Resident Program Manager was unable to provide documentation that services were acquired to	A 152		

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A 152	Continued From page 40 provide repairs to the low water pressure, the broken showerhead, the lack of hot water in one bathroom, or the broken sink/washtub. The Resident Program Manager agreed that debris and bags of leaves made hearty reservoirs for rodents and other pests. Class III	A 152		
A 160 SS=D	59A-36.015(1) FAC Records - Facility The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a [illegible]; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a	A 160		

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A 160	Continued From page 41 bed for a resident who is out of the facility but intending to return pursuant to rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in rule 59A-36.007, F.A.C. (j) All food service records required in rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant	A 160		

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A 160	Continued From page 42 to section 429.41, F.S., and rule chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to section 381.031, F.S., and chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to provide an up to date Admission and Discharge with all required admission and discharge for all residents admitted into the Facility and discharged from the Facility. Findings Included: A review of the Facility's Admission and Discharge Log, conducted on , revealed that the Admission and Discharge Log was not up to date and did not include all required data. Residents #1, #2, #3, #4, #5, #6, #7, #8, and #9 did not have the place that they were admitted from. Residents #2, #6, and #7 did not have a date of admission. Former Residents #8	A 160		

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A 160	Continued From page 43 and #9 did not have the date that the residents were discharged, the place that the residents discharge to, or the reasons that the residents discharged from the Facility. During an interview with the Resident Program Manager, conducted on [redacted] at 12:15pm, the Resident Program Manager agreed that the Admission and Discharge was not up to date and did not include all required data. Class III	A 160		
A 200 SS=G	59A-36.025 FAC Emergency Environmental Control 59A-36.025 Emergency Environmental Control for Assisted Living Facilities. (1) DETAILED EMERGENCY ENVIRONMENTAL CONTROL PLAN. Each assisted living facility shall prepare a detailed plan ("plan") to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency environmental control in the event of the loss of primary electrical power in that assisted living facility which includes the following information: (a) The acquisition of a sufficient alternate power source such as a generator(s), maintained at the assisted living facility, to ensure that current licensees of assisted living facilities will be equipped to ensure [redacted] air temperatures will be maintained at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. 1. The required temperature must be maintained in an area or areas, determined by the assisted living facility, of sufficient size to maintain residents safely at all times and that is appropriate for resident care needs and life safety	A 200		

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A 200	Continued From page 44	A 200		

requirements. For planning purposes, no less than twenty (20) net square per resident must be provided. The assisted living facility may use eighty percent (80%) of its licensed bed capacity as the number of residents to be used in the to determine the required square footage. This may include areas that are less than the entire assisted living facility if the assisted living facility's comprehensive emergency management plan includes allowing a resident to congregate when he or she desires in portions of the building where temperatures will be maintained and includes procedures for monitoring residents for signs of heat related injury as required by this rule. This rule does not prohibit a facility from acting as a receiving provider for evacuees when the conditions stated in section 408.821, F.S. and subsection 59A-36.019(5), F.A.C., are met. The plan shall include information regarding the area(s) within the assisted living facility where the required temperature will be maintained.
2. The alternate power source and fuel supply shall be located in an area(s) in accordance with local zoning and the Florida Building Code.
3. Each assisted living facility is unique in size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and staffing characteristics. Accordingly, this rule does not limit the types of systems or equipment that may be used to achieve temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. The plan shall include information regarding the systems and equipment that will be used by the assisted living facility and the fuel required to operate the systems and equipment.

Agency for Health Care Administration

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A 200	Continued From page 45 a. An assisted living facility in an evacuation zone pursuant to chapter 252, F, S. must maintain an alternative power source and fuel as required by this subsection at all times when the assisted living facility is occupied but is permitted to utilize a mobile generator(s) to enable portability if evacuation is necessary. b. Assisted living facilities located on a single campus with other facilities under common ownership, may share fuel, alternative power resources, and resident space available on the campus if such resources are sufficient to support the requirements of each facility's residents, as specified in this rule. Details regarding how resources will be shared and any necessary movement of residents must be clearly described in the emergency power plan. c. A multistory facility, whose comprehensive emergency management plan is to move residents to a higher floor during a flood or surge event, must place its alternative power source and all necessary additional equipment so it can safely operate in a location protected from flooding or storm surge damage. (b) The acquisition of sufficient fuel, and safe maintenance of that fuel at the facility, to ensure that in the event of the loss of primary electrical power there is sufficient fuel available for the alternate power source to maintain temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours after the loss of primary electrical power during a declared state of emergency. The plan must include information regarding fuel source and fuel storage. 1. Facilities must store minimum amounts of fuel onsite as follows: a. A facility with a licensed capacity of 16 beds or less must store 48 hours of fuel onsite.	A 200		

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A 200	Continued From page 46 b. A facility with a licensed capacity of 17 or more beds must store 72 hours of fuel onsite. 2. An assisted living facility located in an area in a declared state of emergency area pursuant to section 252.36, F.S. that may impact primary power delivery must secure ninety-six (96) hours of fuel. The assisted living facility may utilize portable fuel storage containers for the remaining fuel necessary for ninety-six (96) hours during the period of a declared state of emergency. 3. Piped natural gas is an allowable fuel source and meets the onsite fuel supply requirements under this rule. 4. If local ordinances or other regulations limit the amount of onsite fuel storage for the assisted living facility's location, then the assisted living facility must develop a plan that includes maximum onsite fuel storage allowable by the ordinance or regulation and a reliable method to obtain the maximum additional fuel at least 24 hours prior to depletion of onsite fuel. (c) The acquisition of services necessary to maintain, and test the equipment and its functions to ensure the safe and sufficient operation of the alternate power source maintained at the assisted living facility. (d) The acquisition and maintenance of a . . . monoxide alarm. (2) SUBMISSION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall submit its plan to the local emergency management agency for review within 30 days of the effective date of this rule. Assisted living facility plans previously submitted and approved pursuant to emergency Rule 58AER17-1 will require resubmission only if changes are made to the plan. (b) Each new assisted living facility shall submit the plan required under this rule prior to obtaining	A 200		

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A 200	Continued From page 47	A 200		

a license.
(c) Each existing assisted living facility that undergoes any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of its systems or equipment affecting the facility's compliance with this rule shall amend its plan and submit it to the local emergency management agency for review and approval.
(3) APPROVED PLANS.
(a) Each assisted living facility must maintain a copy of its approved plan in a manner that makes the plan readily available at the licensee's physical address for review by a legally authorized entity. If the plan is maintained in an electronic format, assisted living facility staff must be readily available to access and produce the plan. For purposes of this section, "readily available" means the ability to immediately produce the plan, either in electronic or paper format, upon request.
(b) Within two (2) business days of the approval of the plan from the local emergency management agency, the assisted living facility shall submit in writing proof of the approval to the Agency for Health Care Administration.
(c) The assisted living facility shall submit a consumer-friendly summary of the emergency power plan to the Agency. The Agency shall post the summary and notice of the approval and implementation of the assisted living facility emergency power plans on its website within ten (10) business days of the plan's approval by the local emergency management agency and update within ten (10) business days of implementation.
(4) IMPLEMENTATION OF THE PLAN.
(a) Each assisted living facility licensed prior to the effective date of this rule shall, no later than

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A 200	Continued From page 48 . . . . , ... , have implemented the plan required under this rule. (b) The Agency shall allow an extension up to . . . . to providers in compliance with paragraph (c) below and who can show delays caused by necessary construction, delivery of ordered equipment, zoning or other regulatory approval processes. Assisted living facilities shall notify the Agency that they will utilize the extension and keep the Agency apprised of progress on a quarterly basis to ensure there are no unnecessary delays. If an assisted living facility can show in its quarterly progress reports that unavoidable delays caused by necessary construction, delivery of ordered equipment, zoning or other regulatory approval processes will occur beyond the initial extension date, the assisted living facility may request a waiver pursuant to section 120.542, F.S. (c) During the extension period, an assisted living facility must make arrangements pending full implementation of its plan that provides the residents with an area or areas to congregate that meets the safe indoor air temperature requirements of subsection (1) (a) for a minimum of ninety-six (96) hours. 1. An assisted living facility not located in an evacuation zone must either have an alternative power source onsite or have a contract in place for delivery of an alternative power source and fuel when requested. Within twenty-four (24) hours of the issuance of a state of emergency for an event that may impact primary power delivery for the area of the assisted living facility, it must have the alternative power source and no less than ninety-six (96) hours of fuel stored onsite. 2. An assisted living facility located in an evacuation zone pursuant to chapter 252, F.S. must either:	A 200		

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	AL11967240	A. BUILDING: _____ B. WING _____	11/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 200	Continued From page 49 a. Fully and safely evacuate its residents prior to the arrival of the event; or b. Have an alternative power source and no less than ninety-six (96) hours of fuel stored onsite, within twenty-four (24) hours of the issuance of a state of emergency for the area of the assisted living facility. (d) Each new assisted living facility shall implement the plan required under this rule prior to obtaining a license. (e) Existing assisted living facilities that undergo any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of the systems or equipment affecting the assisted living facility's compliance with this rule shall implement its amended plan concurrent with any such additions, modifications, alterations, refurbishment, renovations or reconstruction. (f) The Agency for Health Care Administration may request cooperation from the State Fire Marshal to conduct inspections to ensure implementation of the plan in compliance with this rule. (5) POLICIES AND PROCEDURES. (a) Each assisted living facility shall develop and implement written policies and procedures to ensure that the assisted living facility can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. The procedures shall ensure that residents do not experience complications from fluctuations in air temperatures inside the facility. Procedures must address the care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury including:	A 200		

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A 200	Continued From page 50 1. The use of cooling devices and equipment; 2. The use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration; 3. Wellness checks by assisted living facility staff to monitor for signs of , and heat injury; and 4. A provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy. (b) Each assisted living facility shall maintain the written policies and procedures in a manner that makes them readily available at the licensee's physical address for review by a legally authorized entity. If the policies and procedures are maintained in an electronic format, assisted living facility staff must be readily available to access the policies and procedures and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce the policies and procedures, either in electronic or paper format, upon request. (c) The written policies and procedures must be readily available for inspection by each resident; each resident's legal representative, designee, surrogate, guardian, attorney in fact, or case manager; each resident's estate; and such additional parties as authorized in writing or by law. (6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this rule, the Agency for Health Care Administration may seek any remedy authorized by chapter 429, part I, or chapter 408, part II, F.S., including, but not limited to, license revocation, license suspension, and the imposition of administrative fines. (7) COMPREHENSIVE EMERGENCY MANAGEMENT PLAN.	A 200		

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A 200	Continued From page 51 (a) Assisted living facilities whose comprehensive emergency management plan is to evacuate must comply with this rule. (b) Each facility whose plan has been approved shall submit the plan as an addendum with any future submissions for approval of its comprehensive emergency management plan. (8) NOTIFICATION. (a) Within five (5) business days, each assisted living facility must notify in writing, unless permission for electronic communication has been granted, each resident and the resident's legal representative: 1. Upon submission of the plan to the local emergency management agency that the plan has been submitted for review and approval; 2. Upon final implementation of the plan by the assisted living facility. (b) Each assisted living facility must maintain a copy of each notification set forth in paragraph (a) above in a manner that makes each notification readily available at the licensee's physical address for review by a legally authorized entity. If the notifications are maintained in an electronic format, facility staff must be readily available to access and produce the notifications. For purposes of this section, "readily available" means the ability to immediately produce the notifications, either in electronic or paper format, upon request. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to acquire service to test and maintain the alternate power source (generator) and failed to maintain enough fuel onsite to run the generator as required. Additionally, the facility failed to notify residents and/or their responsible parties in writing regarding the approved Comprehensive	A 200		

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A 200	Continued From page 52 Emergency Power Plan (CEMP) implementation. Findings Included: During an observation of the generator, conducted on at 11:00am, the generator had physical damage (dents) to the top and side (Photographic Evidence Obtained). During a request for the test and maintenance logs for the generator from the Administrator, conducted on at 10:10am, there were no documents provided. During a request to review written notification to residents and/or their responsible parties that the Facility had submitted their CEMP to the local Emergency Management Office and had an approved CEMP from the Administrator, conducted on at 10:10am, there were no documents provided. During a request to review the amount of fuel that was onsite from the Administrator, conducted on at 10:10am, there were no documents provided or sufficient observed on site. During an interview with the Resident Program Manager, conducted on at 12:15pm, the Program Manager was unable to provide evidence that the Facility acquired services to test and maintain the generator. The Program Manager was unable to provide evidence of the amount of fuel onsite. The Program Manager was unable to provide evidence that the Facility notified residents and/or their responsible parties in writing regarding the approval and implementation of the CEMP. Class II	A 200		

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