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
	AL11942866	A. BUILDING: _____ B. WING _____	01/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS ASSISTED LIVING (THE)	26455 RAMPART BLVD. PUNTA GORDA, FL 33983

(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 staff interview, the facility failed to maintain the employment status of all employees within the clearinghouse and report any changes of status within 10 business days on the employee roster for 3 (Staff D, E and F) of 4 files reviewed. The findings included:	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 Review of the employee records for Staff D revealed a hire date of [redacted] and a termination date of [redacted]. Staff D was not listed on the employee roster. Record review revealed Staff E, was hired [redacted] as a Resident Aide. Review of the Agency's clearing house employee roster revealed Staff E was added on the clearing house roster on [redacted]. Record review revealed Staff F, was hired [redacted] as a Resident Aide. Review of the Agency's clearing house employee roster revealed Staff F was added on the clearing house roster on [redacted]. On [redacted] at 2:30 p.m., in an interview with the Administrator he stated he thought there was a probationary period allowed where new employees could work before being added to the clearinghouse, and when he gets busy he forgets to add the employees and they were added late. Unclassified	CZ814		
CZ815	408.809; 435.02(2); 435.06 FS Background Screening; Prohibited Offenses 408.809 Background screening; prohibited offenses.- (1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are considered employees for the purposes of conducting screening under chapter 435: (a) The licensee, if an individual. (b) The administrator or a similarly titled person	CZ815		

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

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CZ815	Continued From page 3	CZ815		

of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction:
(a) Any authorizing statutes, if the offense was a felony.
(b) This chapter, if the offense was a felony.
(c) Section 409.920, relating to Medicaid provider fraud.
(d) Section 409.9201, relating to Medicaid fraud.
(e) Section 741.28, relating to domestic violence.
(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.
(g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.
(h) Section 817.234, relating to false and fraudulent insurance claims.
(i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.
(j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.
(k) Section 817.505, relating to patient brokering.
(l) Section 817.568, relating to criminal use of personal identification information.
(m) Section 817.60, relating to obtaining a credit card through fraudulent means.
(n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.
(o) Section 831.01, relating to forgery.
(p) Section 831.02, relating to uttering forged instruments.
(q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.

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CZ815	Continued From page 4 (r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes. (s) Section 831.30, relating to fraud in obtaining medicinal drugs. (t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony. (u) Section 895.03, relating to racketeering and collection of unlawful debts. (v) Section 896.101, relating to the Florida Money Laundering Act. If, upon rescreening, a person who is currently employed or [redacted] with a licensee and was screened and qualified under s. 435.04 has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency no later than 30 days after receipt of the rescreening results by the person. (5) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening. (6)(a) As provided in chapter 435, the agency	CZ815		

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CZ815	Continued From page 5	CZ815		

may grant an exemption from disqualification to a person who is subject to this section and who:
1. Does not have an active professional license or certification from the Department of Health; or
2. Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification.
(b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may grant an exemption from disqualification to a person who is subject to this section and who has received a professional license or certification from the Department of Health or a regulatory board within that department and that person is providing a service within the scope of his or her licensed or certified practice.
(7) The agency and the Department of Health may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, chapter 435, and authorizing statutes requiring background screening and to implement and adopt criteria relating to retaining , , pursuant to s. 943.05(2).
(8) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this section, terminates the person against whom the report was issued, whether or not that person has filed for an exemption with the Department of Health or the agency.

435.06 Exclusion from employment.-
(1) If an employer or agency has reasonable cause to believe that grounds exist for the denial or termination of employment of any employee as

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CZ815	Continued From page 6 a result of background screening, it shall notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity. (2)(a) An employer may not hire, select, or otherwise allow an employee to have contact with any person that would place the employee in a role that requires background screening until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of employment. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select, or otherwise allow the employee to have contact with any person that would place the employee in a role that requires background screening unless the employee is granted an exemption for the disqualification by the agency as provided under s. 435.07. (b) If an employer becomes aware that an employee has been for a disqualifying offense, the employer must remove the employee from contact with any person that places the employee in a role that requires background screening until the is resolved in a way that the employer determines that the employee is still eligible for employment under this chapter. (c) The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of this chapter or place the employee in a position for which background screening is not required unless the employee is granted an exemption	CZ815		

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CZ815	Continued From page 7 from disqualification pursuant to s. 435.07. (d) An employer may hire an employee to a position that requires background screening before the employee completes the screening process for training and orientation purposes. However, the employee may not have direct contact with [redacted] persons until the screening process is completed and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment. (3) Any employee who refuses to cooperate in such screening or refuses to timely submit the information necessary to complete the screening, including [redacted], if required, must be disqualified for employment in such position or, if employed, must be dismissed. (4) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages against, an employer that, upon notice of a conviction or [redacted] for a disqualifying offense listed under this chapter, terminates the person against whom the report was issued or who was [redacted], regardless of whether or not that person has filed for an exemption pursuant to this chapter. 435.02 Definitions.-For the purposes of this chapter, the term: (2) "Employee" means any person required by law to be screened pursuant to this chapter, including, but not limited to, persons who are contractors, licensees, or volunteers. This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to obtain a background screen prior to hiring, selecting or otherwise allowing an employee to have contact with any	CZ815		

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CZ815	Continued From page 8 person that would place the employee in a role that requires background screening for 1 (Staff D) of 4 staff reviewed. The findings included: Review of the employee records for Staff D revealed a hire date of . Staff D was hired as a resident aide. The ACHA Background Screen Website showed Staff D was not eligible to work with persons. On at 10:13 a.m., the Administrator said Staff D had been an employee at the facility and had worked on the floor directly with residents. The Administrator said when they sent him for background screening, he was found to be not eligible for employment and was terminated on . The Administrator said didn't get background screen upon hire as he was in a probationary period. Unclassified	CZ815		

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A 000	Initial Comments An unannounced re-licensure, emergency power plan monitoring, focused control and complaint survey for complaint # 2020019010, #2020017669 and #2020020451 was conducted through at The Courtyards Assisted Living, an assisted living facility in Punta Gorda, Florida. Complaint #2020019010 was substantiated at A0030. Complaint #2020017669 was substantiated at A0025. Complaint #2020020451 was substantiated at A0030 & A0165. The following is a description of the deficiencies:	A 000		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident ' s representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the	A 025		

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A 025	Continued From page 1 necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and staff and family interview, the facility failed to provide care and services appropriate to the needs of residents	A 025		

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A 025	Continued From page 2 and maintain a general awareness of the residents' whereabouts for 1 (Resident #11) of 1 residents reviewed for elopement. The findings included: Review of the facility's adverse incident reports revealed Resident #11 had eloped from the facility twice. The first report indicated that Resident #11 moved into the facility on . On . . . . at 5:00 a.m. door alarms sounded. A staff member checked all doors and completed a resident check and Resident #11 was last seen at 5:30 a.m. The staff member forgot to re-alarm the doors. On . . . . . at 8:00 a.m., Resident #11 was noted to be missing and a search of the facility and grounds did not find her on the premises. Resident Supervisor Staff A contacted the Sheriff's office and Resident #11's son. Resident #11's son said the Sheriff's office had found Resident #11 at the local supermarket and had brought her to his house. The son returned her to the facility at approximately 9:00 a.m. The second adverse incident report indicated at 9:45 a.m. on . . . . . , a neighbor called the facility informing them Resident #11 was on their lawn. Staff A called the Sheriff's office to advise them that Resident #11 was not at the facility, informed the Administrator of the incident and drove to the neighbor's house to pick up Resident #11 and returned her to the facility. Resident #11's Health Assessment Form dated indicated she had and was oriented to self only, with . . . . . . Review of Resident #11's progress notes revealed the following: Resident #11 ran out the door claiming she was headed to New Jersey. Staff ran outside to get her and	A 025		

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brought her . . . in. . . . . Resident #11 set the alarm off two times walking out of the door. The second time she walked all the way to the dumpster. Resident #11 was upset walking down the hallway then door number 4 alarm started going off. We got down there and she open the door and tried going out. We talked her into coming in and we got her to calm down and go in her room. . . . . During lunch door number 8 alarm started going off. We got there and the resident was outside. We tried to talk her in and she started to fight saying she was not going . . . in. I walked outside started talking to her and we got her inside. . . . . Resident 11 tried to get out the locked doors five times and wants to fight with you every time you make her come . . . in door. . . . . Resident tried to get out five times today and keeps saying she is going home and gets very mad when you bring her in. She went out the side door screaming help, she punched me and tried to bite, tried to throw a chair. Got her . . . in her room after 20 minutes of fighting.

On at 11:25 a.m., Resident #11 was observed walking through hallway. She did not have a guard around her ankle or . .

On at 3:26 p.m., Resident #11's son said the first time he found out she had eloped was when the Sheriffs office knocked on his door and said they found her. The second time they found her at a neighbors house. Resident #11's son said the Sheriffs' office had a program where they put a plastic . . device on her with a tracking device but she pried off within a day. The son said they told us they could handle her there, but apparently they couldn't. The son said that was going to be her last week at the facility as he is

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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 025	Continued From page 4 moving her to a memory care facility. On [redacted] at 1:17 p.m., Staff A (Resident Aide Supervisor) said when Resident #11 was admitted they could tell she was pretty bad [redacted]. Staff A said Resident #11 was admitted one day and when she came [redacted] to work the next day she was missing. Staff A said the boy on the night shift didn't even know she was gone. Staff A said when things started going really bad with her always trying to get out, they kept going to the Administrator to tell him she need to go to a locked unit, a memory care or something as you had to stay on top of her 24/7. Staff A said the second time she got out she had to go get her at a neighbors house. She had gone into a room where some construction was going on, knocked the screen out & crawled out the window. She had been caught previously trying to crawl out her bedroom window. Staff A said she told the Administrator all the time that Resident #11 shouldn't be here but he said pretty much all we can do is keep an [redacted] on her, make sure the alarms are set & make sure she doesn't get out. But that is hard to do your job & stay on her 24/7. Staff A said they referred her to a [redacted] Nurse Practitioner but they had a difficult time getting her on medications as the family didn't want her on psych medications. On [redacted] at 3:03 p.m., Staff G (Resident Aide) said with Resident #11 it was a handful. He said he was just told them to keep an [redacted] on her, but that became very difficult when they are short staffed and she can slip out the door. Staff G said he felt Administration should have looked into her background and screened her more closely before bringing her, as she needed closer supervision or a memory unit. Staff G said you needed to keep an [redacted] on her constantly and	A 025		

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A 025	Continued From page 5 there were 45 other people to take care of. On at 11:10 a.m., Staff C (Assistant administrator) said after Resident #11's elopement in nothing was really put in place, just to keep an , on her and keep the doors locked. Staff C said the doors are locked but they do allow for egress if you push on them for 15 seconds they will open and an alarm sounds. Staff C said no resolutions were put in place to diminish her attempts. On at 1:19 p.m., the Administrator said after the elopement they did a re-training which was basically remind staff to key in the alarm. He said he had no documentation of re-training. He said the family had gotten a guard and they were moving Resident #11 to another facility. Class III	A 025		
A 030	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able	A 030		

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

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facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside.
(g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical .

429.28 Resident bill of rights.-
(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:
(a) Live in a safe and decent living environment, free from and neglect.
(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.
(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of

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A 030	Continued From page 8 other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care [illegible], and the performance of health	A 030		

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care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community.
(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.
(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without . . . , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.
(2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a

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prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder . . . . . Hotline operated by the Department of Children and Families, and, if applicable, ... , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder . . . . Hotline operated by the Department of Children and Families, and , Rights Florida.

429.27 Property and personal affairs of residents.-
(1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated . . , ... or . . , ... under state law, managing his or her own affairs.
(b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall

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A 030	Continued From page 11 such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation, record review, and staff and resident interview, the facility failed to ensure residents live in a safe, decent living environment free from and neglect for 3 (Residents #13, #14, and #4) of 3 residents reviewed for grievance alleging . The facility also failed to safeguard residents' well-being by failing to follow current control standards related to COVID-19 recommendations set forth by Centers for Control and Prevention (CDC). Refer to https://www.cdc.gov/coronavirus/2019-ncov/hcp/assisted-living.html. The findings included: 1. Record review of the grievance log revealed Resident #13 filed a grievance on . The grievance indicated Staff D had raised his voice to her, cussed at her, and physically assaulted her. The grievance also alleged that Resident Aide ( ) Staff D threw Resident #14 against the wall resulting in an injury to his and spit on him. The grievance also alleged Staff G and Resident #4 had been witness to the incident. Review of the Agency background screening website showed Staff D to be not eligible for working with persons. The clearinghouse also revealed Staff D had never been added to the facility roster.	A 030		

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A 030	Continued From page 12 On . . . at 1:49 p.m., Resident #13 said she had an incident on with Staff D. Resident #13 said she had not received her nightly snack by 8:45 p.m., so she got into her wheelchair and went into the hallway to find Staff D to ask about the snack. She said when she found Staff D, he told her to go get it herself. Resident #13 said she told him it is difficult for her to get into her wheelchair and put another . , . . tank on to come out of her room to which Staff D responded with, you're in your chair now, aren't you? Resident #13 said she proceeded to the kitchen and when she found little to select from she told Staff D he needs to start coming to her room with the snack, at which time an argument ensued with Staff D telling her to "F ... Off" over and over again. She said at this time she went to find Resident Aide Staff G to tell him what happened and during this time Staff D repeatedly called her a f ...ing liar. She said Staff D then went to mop the dining room floor and when she entered the dining room, he told her to get the F ... off my floor. She said she went in the courtyard and when she did, Staff D locked the door behind her so she couldn't get . . . in. She said she knocked on the door, but Staff D wouldn't let her in and finally another resident walked by and opened it for her. She said when she was in the building Staff D came up behind her and said F ... off you F ... ... B .... while repeatedly gesturing at her with his middle . . . Resident #13 said she yelled at him to get away from her 3 times and he then rushed at her and with his right dug into the corner of her & , jolting her . . . . . Resident #13 said at this time Resident #14 approached and said: "Hey, you don't hit a woman." At this time Resident #13 said she went to find Staff G and when she returned Resident #14's was . . . . and he said Staff D threw him up against the wall and	A 030		

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spit on him. Resident #13 said Staff D continued a constant stream of foul language calling her a f ... ... B .... and waving his _ around dramatically while grinning and saying F ... Y .... He then said: "all this over a snack? Look at you, you don't need a snack.: Resident #13 said at this time she was frantic with fear and disbelief and asked Staff G to call the Administrator. She said Staff G called the Administrator and said the Administrator advised him to tell Staff D to go outside and cool off.

On ... at 12:00 p.m., Resident #14 said he had had some incidents with Staff D. He said Staff D had a "nasty, disgusting ... and every other word out of his was "F', in front of woman, everywhere. He was disgusting that guy." Resident #14 said he witnessed Staff D continuously poke Resident #13 in the ... on . Resident #14 lifted his and showed me a large scab on his left ... (photographic evidence taken), and said the same evening, he was trying to get into his room when Staff D told me to get out of his way and pushed him in to a wall. Resident 14 said he was in a wheelchair and couldn't catch him and when Staff D was about 5 .. away Staff D spit on him. Resident #14 said as soon as it happened Resident #13 called the Administrator and told him about, but he didn't really do anything. Resident #14 said the Administrator never came to him and talked to him about it. Resident # 14 said Staff D quit working there about a week or so after the incident.

On at 12:00 p.m., Resident #4 said she witnessed most of the incident between Resident #13 and Staff D but did not witness when Staff D physically hit Resident #13. She said the incident started over him missing some residents when

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giving the snacks in the evening. She said she went to Resident #13's room and they both had not gotten a snack, so they went to find Staff D. Resident #4 said Resident #13 was tired and out of breath when they found Staff D and when Resident #13 asked him why he did not come to her room to give her a snack, Staff D told her if she wants the snack to go get her own snack. Resident #4 said by that time other residents were gathering and complaining they had not gotten a snack either, and Staff D started yelling and using foul language and that is when she left. Resident #4 said she could still hear the commotion from her room and the staff member continued to use foul language. She said she felt stressed at that time, which is why she went to her room, but the following day when Resident #13 said he had hit her and she saw a on her by her , she felt fearful. Resident #4 thought that with Staff D hitting a resident he would have been terminated but he continued to work in the facility and would rub it in every time he saw Resident #13.

On at 3:03 p.m., Staff G Resident Assistant said on he was helping another resident. He said around 8:00 p.m. or 9:00 p.m., he could hear Staff D yelling and using curse words. Staff G said Resident #13 came to him and said Staff D had poked her in the and . Staff G said he did not see any of the incident with his own , but he could hear it. Staff G said during this time Staff D also had an issue with Resident #14. Staff G said Resident #14 came around the corner and said Staff D had hit him. Staff G said he observed a with skin peeled on the left . He said Resident #13 asked him to call the Administrator and while he was on the phone with the Administrator, Staff D came out and was yelling

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and cursing using the "F" word and telling Resident #13 she needed to lose . Staff G said he didn't feel that was right and it was messed up. Staff G said the Administrator told him to tell Staff D to go home and Staff D left for a little bit but must have come to work the midnight shift because when Staff G reported to work the next morning at 7 a.m., Staff D was there. Staff G said the Administrator did come and talk to him about the incident and Staff G said he recommended Staff D should be let go.

On at 10:13 a.m., the Administrator said Staff D had worked there but when they got his background screen, he was found to be not eligible for employment and was terminated. The Administrator said he had spoken to a few people about the incident and they all told him it was Resident #13 who was chasing Staff D around the building. The Administrator admitted Staff D continued working in the building after the allegations of were received. He said he had no documentation and never did a full investigation of the grievance as Staff D was terminated. The Administrator said he did not report the allegations of to the Department of Children and Families as he felt the allegations were unfounded.

On at 11:10 a.m., Assistant Administrator Staff C said she was aware of the incident involving Resident #13 and Staff D. Staff C said the incident had occurred on which was a weekend, and when she arrived Monday both Staff D and Resident #13 told her about it. Staff C said she advised Resident #13 to write up the incident. Staff C said Staff D was allowed to come and work after the allegations and was never suspended pending investigation. Staff C said to her knowledge this was never

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A 030	Continued From page 16 reported to the Department of Children & Families. Staff C said Staff D quit when she found him sleeping on the couch on . . . . at 7:30 a.m. and was angry saying he does his job; this isn't the place for him, and he was told there was nothing to do on midnights. Staff C said she did not believe the grievance was followed up on as the Administrator said the problem was not there anymore and no further follow up was done. 2. CDC guidance recommends screening of all persons entering the facility to include temperature checks, and completion of a questionnaire about symptoms and potential exposure. The CDC guidance further recommends enforcing social distancing between residents, ensure all residents wear a cloth . . . covering for source control whenever they leave their room or are around others. Healthcare personnel should wear a facemask, at all times while they are in the healthcare facility. (DD - not sure if this all under the same tag? - HRH) On . . . . at 9:00 a.m., upon arrival and during the tour of the facility, observations were noted: Staff J Driver sitting at front desk not wearing a mask. Staff C Assistant Administrator in the facility, introduced herself not wearing a mask or covering. Staff K Secretary performed temperature reading of the surveyor team not wearing a . . . . mask and continued to sit at the front desk, wearing no . . . mask. Staff L in the television room with residents not wearing a mask or . . . covering. Staff E in the dining room with residents not wearing a mask or . . . covering. Residents #!5, #16 and #17, were sitting in the	A 030		

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	AL11942866	A. BUILDING: _____ B. WING _____	01/14/2021

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A 030	Continued From page 17 television room, not wearing any . . . coverings and no social distancing of at least 6 between them. Resident #12 was walking around in the facility not wearing any coverings, Resident #18 was walking around in the facility not wearing any coverings. Staff were not encouraging residents to don masks around others or when out of their rooms. On at 10:29 a.m., Resident #2 stated no one in the facility wears a mask, not even the staff, and no one has told him he should wear a mask when he is not in his room or around others in the facility. On at 11:15 a.m., Resident #4 stated no one in the facility ever wears masks, she said, "only if an inspector or the state is in the facility, the staff would wear a mask", but other than that the staff never wears masks. She said staff had never educated the residents or her about wearing a mask when not in their room or around others, she said they have never even offered her a mask. at 11:49 a.m., observation of Resident #12 and Resident #19 sitting in the television room not wearing any masks and no social distancing of 6 . . . between them. On . . . at 1:09 p.m., Staff L stated she has not received any training from facility management related to COVID-19 and . . . . control procedures, she stated the residents at the facility and staff don't wear . . . masks while at the facility, she said management has made it known that if the facility had no positive COVID-19 cases the residents and staff don't have to wear masks, so no one wears masks and the staff don't encourage the residents to wear	A 030		

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A 030	Continued From page 18 any masks. On . . . at 2:02 p.m., Staff E, stated she has not received any training for control related to COVID-19, and she is not screened when entering the facility. She said the residents are not encouraged to wear masks by staff when they exit their rooms, and staff are not required to wear masks in the facility, she stated no one in the facility wears masks, from the front to the . . . staff walk around the facility not wearing a mask. On at 9:40 a.m., observation of Staff K and Staff C at the front desk, not wearing any masks and no social distancing between them. On at 11:05 a.m., Staff C stated she had not received any training related to . . . control and COVID-19 and the staff had not received any training either. She said staff had been informed by the Administrator, residents don't have to wear masks within the facility when not in their rooms or are around others, and if staff have a negative COVID-19 test result, they don't have to wear masks in the facility. She confirmed the staff don't wear masks when in the facility and there is no social distancing observed by residents within the facility, she said she had spoken with the Administrator informing him the residents need to social distance when in common areas and was informed they don't have to do that. On . . . at 11:22 a.m., in an interview with Staff K, she stated she does the screening for persons entering the facility, and she was never informed staff were to be screened for temperatures with questionnaire/signs and symptoms at the start of shift or when entering	A 030		

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A 030	Continued From page 19 the facility. She confirmed she does not screen any staff when entering the facility the staff just come in and punch in and go to work. On [redacted] at 11:30 a.m., in an interview Staff C confirmed staff are not screened when entering the facility for start of shift, only visitors entering the facility are screened, and there is no documentation to show staff being screened. On [redacted] at 11:35 a.m., the Administrator confirmed there was no documentation for screening of facility staff when entering the facility. He stated: "he provides a thermometer for screening for temperature, but does not enforce the screening for staff." He stated staff don't have to encourage the residents to wear a masks when out of their rooms and around others as this is their house, and they don't have to wear a mask in their house, so the residents don't have to wear mask in the facility. He said, "he gives the staff masks, but he does not enforce them wearing the masks in the facility, they can wear them if they want to." On [redacted] at 1:47 p.m., in an interview with Staff A stated she does not wear a mask in the facility, as the Administrator does not enforce the employees to wear masks in the facility. They have been told if there are no cases in the facility they don't have to wear masks. Class II	A 030		
A 081	429.52(1 & 7) FS; 59A-36.011([redacted]) FAC Training - Staff In-Service 429.52(1) (1)Each new assisted living facility employee who	A 081		

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A 081	Continued From page 20 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 inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice 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. (d) In addition to topics that may be chosen by the facility administrator, the preservice	A 081		

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A 081	Continued From page 21 orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when	A 081		

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A 081	Continued From page 22 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 ensure facility employees complete the in-service training required by Florida Administrative Code within 30 days of employment, and provide at least a 2-hour pre-service orientation prior to interacting with residents for 1 (Staff E) of 3 employee files reviewed.	A 081		

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A 081	Continued From page 23 The findings included: On . . . . a review of Staff E's employee file revealed a hire date of as a resident aide. Staff E's file failed to contain documentation of having completed a pre-service orientation prior to interacting with residents, ... Control training, Activities of Daily Living and Behavioral needs training, Elopement response training, Reporting Major Incidents/Adverse Incidents/Facility Emergency Procedures, Incident Report Training, Resident Rights and Recognizing/Reporting . . . . and Neglect training, and Nutrition and Safe Food Handling within 30 days of hire. On at 3:15 p.m., the Administrator acknowledged the trainings were not done within 30 days of hire. Class III	A 081		
A 082	59A-36.011(4) FAC Training - / . . (4) . . . . . / . . . . . (. . . / . . .). Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on and , including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule. This Statute or Rule is not met as evidenced by:	A 082		

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A 082	Continued From page 24 Based on record review and interview, the facility failed to ensure facility employees complete a one-time education course on and and maintain documentation of completion for 1 (Staff E) of 3 employee files reviewed for training. The findings included: On a review of Staff E's employee file revealed a hire date of as a resident aide. Staff E's employee file contained no documentation of having completed a course on within 30 days of hire. On at 3:15 p.m., the Administrator acknowledged the trainings was not done within 30 days of hire. Class III	A 082		
A 090	59A-36.011(11) FAC Training - (11) TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding within 30 days after employment. (c) Training shall consist of the information	A 090		

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A 090	Continued From page 25 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 ensure facility employees complete at least one hour of training in the facility's policies and procedures regarding . . . . . ( ) within 30 days after employment and maintain documentation of completion for 1 (Staff E) of 3 employee files reviewed. The findings included: On a review of Staff E's employee file revealed a hire date of . . . . . as a resident aide. Staff E's file contained no documentation of having completed an in-service on . . On . . . . at 3:15 p.m., the Administrator acknowledged the training was not done within 30 days of hire. Class III	A 090		
A 152	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility	A 152		

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A 152	Continued From page 26 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, [illegible] or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be [illegible]. This Statute or Rule is not met as evidenced by: Based on observation and staff and resident interview, the facility failed to provide a safe, clean living environment free of hazards. The findings included: On [illegible] at 9:07 a.m., a clear bag containing a dirty brief and used wipes was noted on the floor in the hallway outside the dining room. (photographic evidence obtained) On [illegible] at 9:15 a.m., a dried creamy white substance was noted to be on the hallway floor	A 152		

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A 152	Continued From page 27 near . . # . . On . . . . at 9:15 a.m., this same dried substance was still noted to be on floor. On . . . . at 3:45 p.m. the same dried substance was still on the floor. (photographic evidence obtained) On . . . . at 9:45 a.m., Resident #6 said the housekeeper refuses to clean his room. He said they are only supposed to clean his room when he is present as he has had money go missing in the past. He said his room is supposed to be cleaned on Tuesdays and it was Wednesday and no one had cleaned it. At this time a dried brown substance was noted to be on the walls near the toilet. (photographic evidence obtained) On . . . . at 11:40 a.m., Resident #8 said the housekeeper has only done her or 2 times in the past 6 weeks. Resident #8 said it was supposed to be cleaned every Thursday. Resident #8 said one time the housekeeper refused to clean her room at all because she had a box on the floor and it had to be moved. At this time, the floor was noted to be dirty, the toilet rim was noted to be dirty and a large hole was in the wall behind the door. (photographic evidence obtained) On . . . . at 12:43 p.m., Staff B said she had been the housekeeper for about months and she is the only housekeeper. Staff B said if the facility is short on resident aides or medication technicians, she is pulled from housekeeping to do that. Staff B says it is fair to say there are times she can't get it all done and some rooms are missed and the hallways will not be cleaned. She said it has been as recent as this week that she had been pulled from housekeeping to work as an aide.	A 152		

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A 152	Continued From page 28 On . . . at 1:17 p.m., Staff A said they have been very short staffed and some people are working 2 and 3 shifts. Staff A said overnight shift is supposed to do laundry but haven't been doing it. Staff A said in the last few weeks, the housekeeper has been pulled almost every day for the last two weeks to help out as a resident aide or medication technician. On at 11:10 a.m., Staff C agreed residents are not getting their rooms cleaned weekly as they are supposed to. Staff C said the housekeeper helps in the kitchen, and on the floor when they are short handed. Staff C said the housekeeper is pulled at least twice a week and if she's pulled, the housekeeping work just doesn't get done. Staff C said the resident aides are supposed to help with things as they see them, but they don't. On . . . at 11:00 a.m., the Administrator said housekeeping is supposed to be provided one time a week and as needed. The Administrator admitted they need another housekeeper but it had been hard to find help. On . . at 10:20 a.m., Observations in . . # Included: 1. a dried brown substance was noted on the toilet seat in the bathroom of room, 2. brown debris and stains were noted on the bathroom shower floor, 3. grime and debris noted around toilet bowl on floor in bathroom, 4. a wrapped peanut butter and jelly sandwich was noted sitting on dresser dated . , 5. the ceiling fan in room was also noted to have no blades. (photographic evidence obtained)	A 152		

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A 152	Continued From page 29 On . . . . at 11:32 a.m., observations in . . # included: 1. debris and grime on cupboard next to coffee pot in room, 2. a sponge stained with grime and debris on bathroom sink countertop, 3. grime and debris on coffee pot, 4. grime, debris, and black substance on sink faucets, and sink water constantly dripping/running, 5. debris, grime, and brown stains around the toilet bowl base on the floor, 6. the floor at the entrance to the room heavily stained and soiled. Black substance on wall in room. Resident #5 stated her room has not been cleaned for a while and her sink has been like that for a while and no one has fixed it. On at 9:18 a.m., both rooms were noted to be in the same condition. (photographic evidence obtained) On at 1:10 p.m., Assistant Administrator Staff C and Staff I confirmed the conditions in # # . . Staff I said the Administrator knew about the fan in # for a while and has done nothing about it, and he is waiting on the plumber to fix the sink in # . Class III	A 152		
A 165	429.23(&) FS; 59A-36.016 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality	A 165		

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	AL11942866	A. BUILDING: _____ B. WING _____	01/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS ASSISTED LIVING (THE)	26455 RAMPART BLVD. PUNTA GORDA, FL 33983

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A 165	Continued From page 30 assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident ' s condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency ' s online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse	A 165		

Agency for Health Care Administration

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A 165	Continued From page 31 incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility ' s investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency ' s online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility ' s investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report	A 165		

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A 165	Continued From page 32 this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. 59A-36.016 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1), above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to report allegations of . . . . to the Department of Children and Families (DCF) as required under Chapter #415. The facility also failed to provide within 1 business day after the occurrence of an adverse incident a preliminary report and within 15 days a full report to the Agency on all adverse incidents including the results of the facilities investigation into the adverse incident The findings included:	A 165		

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A 165	Continued From page 33 1. Review of the grievance log revealed Resident #13 filed a grievance on . The grievance indicated that on Staff D had raised his voice to her, cussed at her, and physically assaulted her. The grievance also alleged that Staff D threw Resident #14 against the wall resulting in an injury to his and spit on him. Review of the agency Background Screening website showed Staff D to be not eligible for working with persons. Clearinghouse also revealed Staff D had never been added to the facility roster. On at 10:13 a.m., the Administrator said he did not report the allegation of to the Department of Children & Families as he had spoken with several people named in the grievance and he felt the allegations were unfounded. Administrator said he had no documentation that he did a formal investigation of the claims because Staff D no longer worked at the facility. The Administrator said Staff D been hired on and had worked directly with the residents. Administrator said when they got the background screen in Staff D was found to be not eligible for employment. Administrator said didn't get background screen upon hire as Staff D had been in a probationary period. Staff D's last day of work at the facility was . 2. On at 10:25 a.m., Resident #7 said she had $756. go missing from her purse in her room. Resident #7 said she told the Administrator and Assistant Administrator, but they didn't do anything, they just said I could call the police and I had to report it myself because it would be hearsay if its anyone else reporting. She said the police came to the facility and provided a police	A 165		

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A 165	Continued From page 34 report dated . . . . . for a grand theft investigation. On at 2:04 p.m., Activities Director Staff H said she had $150 go missing a few weeks ago. She said she filed a police report. She said the police were called and came to the facility. Staff H said there were 3 employees and 2 residents that all had money stolen in the same day. Staff H said this was reported to the Administrator who did not investigate, he just said he is not responsible for any monies that come up missing with the residents or staff and that we should call the Sheriff. Staff H said the Sheriff came and . . . . were taken off Resident #7's empty money envelope. On at 11:26 a.m., Resident #8 said the facility had been under . . . . . and she had not been able to get to the bank. She said she had somewhere between $300 and $400 Go missing from her room on . She said the money was tucked away in a very odd spot, so someone had to be going through her things to find it. Resident #8 said she went immediately to tell Assistant Administrator Staff C and was told she was welcome to call the police if she wanted to. Resident #8 said she did call the police but didn't think to keep the police report. Resident #8 said a few days later she was called to speak with police officers out front because 2 other people were robbed, Staff H of about $100 and Resident #7 of $750 or so. Resident #8 said when she went out front, the officer realized he had already been to speak with her a few days prior. Resident #8 said as far as she knows, the Administrator had doing nothing about it. On at 1:19 p.m., the Administrator said he didn't know if there was any money missing as he	A 165		

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A 165	Continued From page 35 had never seen the money that they lost. He said the only thing he can do is see if they have misplaced it and try to look for it in their rooms. He said he was aware the cops were there, and they took [redacted]. The Administrator agrees he did not file a report with the agency and that was his mistake. Class II	A 165		