

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966877</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/16/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ROSEMONT GARDENS, INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1842 KREIDT DR<br/>ORLANDO, FL 32818</b>                                     |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 000                                                            | Initial Comments<br><br>A re-licensure survey, an control<br>assessment and generator assessment were<br>conducted at Rosemont Gardens Inc. Assisted<br>Living Facility on . . . . . The provider had<br>deficiencies at the time of the visit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | A 000                                                                          |                                                                                                                          |  |                                                        |
| A 054<br>SS=D                                                    | 59A-36.008(5) FAC Medication - Records<br><br>(5) MEDICATION RECORDS.<br>(a) For residents who use a pill organizer<br>managed in subsection (2), the facility must keep<br>either the original labeled medication container;<br>or a medication listing with the prescription<br>number, the name and address of the issuing<br>pharmacy, the health care provider's name, the<br>resident's name, the date dispensed, the name<br>and strength of the drug, and the directions for<br>use.<br>(b) The facility must maintain a daily medication<br>observation record for each resident who<br>receives assistance with self-administration of<br>medications or medication administration. A<br>medication observation record must be<br>immediately updated each time the medication is<br>offered or administered and include:<br>1. The name of the resident and any known<br>the resident may have;<br>2. The name of the resident's health care<br>provider and the health care provider's telephone<br>number;<br>3. The name, strength, and directions for use of<br>each medication; and,<br>4. A chart for recording each time the medication<br>is taken, any missed dosages, refusals to take<br>medication as prescribed, or medication errors.<br>(c) For medications that serve as chemical<br>, the facility must, pursuant to section<br>429.41, F.S., maintain a record of the prescribing<br>physician's annual evaluation of the use of the | A 054                                                                          |                                                                                                                          |  |                                                        |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966877</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/16/2021</b> |
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**ROSEMONT GARDENS, INC**

**1842 KREIDT DR  
ORLANDO, FL 32818**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 054                    | <p>Continued From page 1</p> <p>medication.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on observation, review on the Medication<br/>Observation Record (MORs) and interview, the<br/>facility failed to chart recording of medications<br/>taken each time for 3 of 4 sampled residents (#1,<br/>#2, #3).</p> <p>Findings:</p> <p>Observation review on _____ at 11:33 AM, of<br/>three (3) resident's Medication Observation<br/>Record (MORs) for the month of _____<br/>found holes with missing signature on the<br/>following dates:</p> <p>1. Resident #1's _____ MORs revealed<br/>no signature that medications were given for<br/>SOD DR 40 milligrams (mg) on _____</p> <p>For dates _____ and _____, no signature<br/>for medications _____ 10 mg; _____,<br/>300 mg; _____ 50 mcg; _____ 0.5 mg;<br/>_____ 40 mg; _____ 2 mg;<br/>_____ 100 mg; _____ ER 5 mg;<br/>_____ 20 mg; _____ SOD DR 40 mg;<br/>and _____ DR 30 mg not signed off as<br/>required.</p> <p>On _____ at 10:20 AM, an interview with<br/>resident #1 confirmed that she knows her<br/>medications and receives them every day. They<br/>never miss giving them to her.</p> <p>(Photographic Evidence Obtained)</p> <p>2. Resident #2's _____ MORs revealed<br/>no signature for medications on dates _____</p> | A 054               |                                                                                                                          |                          |

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| A 054                    | <p>Continued From page 2</p> <p>and _____ was given for _____ SOD<br/>DR 40 mg; _____ D3 2000 units;<br/>1000 mcg; _____ 50 mg; _____ 10<br/>mg; _____ 50 mg; _____ 81 mg; _____ ER<br/>50 mg; _____ 20 mg; _____ ER 500<br/>mg; _____ 20 mg; _____ 5 mg; and<br/>_____ 15 mg not signed off as required.</p> <p>On _____ at 10:30 AM, an interview with<br/>resident #2 stated that she always gets her<br/>medications on time. She does not miss.</p> <p>(Photographic Evidence Obtained)</p> <p>3. Resident #3's _____ MORs revealed<br/>no signature for medications on dates<br/>and _____ was given for _____ 10 gram,<br/>_____ DR 30 mg; _____ 100 mg;<br/>_____ 40 mg; _____ 100 mg;<br/>_____ 25 mg; _____ 12.5 mg;<br/>_____ 600 mg; and _____ 50 mg<br/>not signed off as required.</p> <p>On _____ at 10:50 AM, an interview with<br/>resident #3 confirmed that she always gets her<br/>medications on time every day.</p> <p>(Photographic Evidence Obtained)</p> <p>On _____ at 11:30 AM, an interview with<br/>caregiver staff A confirmed she was working on<br/>_____ and _____ and forgot to<br/>sign off and agreed she should have signed off<br/>on the MORs immediately as she was trained.</p> <p>On _____ at 11:45 AM, an interview with<br/>Administrator confirmed the findings.</p> <p>Class III</p> | A 054               |                                                                                                                          |                          |

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| A 093                                                            | Continued From page 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | A 093                                                                          |                                                                                                                          |                          |                                                        |
| A 093<br>SS=D                                                    | <p>59A-36.012(2) FAC Food Service - Dietary Standards</p> <p>(2) DIETARY STANDARDS.</p> <p>(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:<br/><a href="http://www.frules.org/Gateway/reference.asp?No=Ref-04003">http://www.frules.org/Gateway/reference.asp?No=Ref-04003</a>, 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:<br/><a href="http://iom.edu/Activities/Nutrition/SummaryDRIs/~media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%202014.pdf">http://iom.edu/Activities/Nutrition/SummaryDRIs/~media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%202014.pdf</a>. Therapeutic diets must meet these nutritional standards to the extent possible.</p> <p>(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.</p> <p>(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</p> | A 093                                                                          |                                                                                                                          |                          |                                                        |

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| A 093                                                            | <p>Continued From page 4</p> <p>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.</p> <p>1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences.</p> <p>2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents.</p> <p>(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.</p> <p>(e) Therapeutic diets must be prepared and served as ordered by the health care provider.</p> <p>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.</p> <p>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.</p> <p>(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</p> | A 093                                                                          |                                                                                                                          |  |                                                        |

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| A 093                                                            | <p>Continued From page 5</p> <p>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.</p> <p>(g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on . . . . .</p> <p>(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.</p> <p>This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to have a written date for 6 months expiration on refilled emergency water stored 1-gallon jugs as required.</p> <p>Findings:</p> <p>Observation on . . . . . at 1 PM, of 20 x 1 gallon jugs that were used and refilled again for the emergency water usage but did not have the 6 months expiration date written on them.</p> | A 093                                                                          |                                                                                                                          |  |                                                        |

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| A 093                                                            | Continued From page 6<br><br>The requirement of emergency water to have stored on _____ with census of 4 resident x 1 gallon per day=4 x 3 days=12 gallons total was met.<br><br>On _____ at 1:05 PM, an interview with Administrator confirmed the findings.<br><br>Class III                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | A 093                                                                          |                                                                                                                          |  |                                                        |
| A 160<br>SS=D                                                    | 59A-36.015(1) FAC Records - Facility<br><br>The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request.<br>(1) FACILITY RECORDS. Facility records must include:<br>(a) The facility's license displayed in a conspicuous and public place within the facility.<br>(b) An up-to-date admission and discharge log listing the names of all residents and each resident's:<br>1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a _____; and,<br>2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge | A 160                                                                          |                                                                                                                          |  |                                                        |

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| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 160                                                            | Continued From page 7<br><br>requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of .<br>(c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b).<br>(d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in rule 59A-36.019, F.A.C., that must be readily available by facility staff.<br>(e) The facility's liability insurance policy required in rule 59A-36.013, F.A.C.<br>(f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by rule 59A-36.013, F.A.C.<br>(g) The admission package presented to new or prospective residents (less the resident's contract) described in rule 59A-36.006, F.A.C.<br>(h) If the facility advertises that it provides special care for persons with _____'s _____ or related _____, a copy of all such facility advertisements as required by section 429.177, F.S.<br>(i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in rule 59A-36.007, F.A.C.<br>(j) All food service records required in rule 59A-36.012, F.A.C., including menus planned 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. | A 160                                                                          |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966877</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/16/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ROSEMONT GARDENS, INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1842 KREIDT DR<br/>ORLANDO, FL 32818</b>                                     |                          |                                                        |
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| A 160                                                            | <p>Continued From page 8</p> <p>(k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to section 429.41, F.S., and rule chapter 69A-40, F.A.C., issued within the last 2 years.</p> <p>(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.</p> <p>(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.</p> <p>(n) The facility's resident elopement response policies and procedures.</p> <p>(o) The facility's documented resident elopement response drills.</p> <p>(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.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on facility's documentation review and interview, the facility failed to obtain an annual satisfactory fire safety inspection report issued by the local authority or the State Fire Marshal as required.</p> <p>Findings:</p> <p>The last fire inspection report dated for _____ revealed the facility failed and not satisfactory from Orange County Fire and Rescue Department.</p> <p>(Photographic Evidence Obtained)</p> | A 160                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966877</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/16/2021</b> |
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**ROSEMONT GARDENS, INC**

**1842 KREIDT DR  
ORLANDO, FL 32818**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
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| A 160                    | Continued From page 9<br><br>On _____ at 12:30 PM, an interview with<br>Administrator confirmed the finding.<br><br>Class III                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | A 160               |                                                                                                                          |                          |
| A 162<br>SS=D            | 59A-36.015(3) FAC Records - Resident<br><br>(3) RESIDENT RECORDS. Resident records<br>must be maintained on the premises and include:<br>(a) Resident demographic data as follows:<br>1. Name,<br>2. _____,<br>3. Race,<br>4. Date of birth,<br>5. Place of birth, if known,<br>6. Social security number,<br>7. Medicaid and/or Medicare number, or name of<br>other health insurance _____,<br>8. Name, address, and telephone number of next<br>of kin, legal representative, or individual<br>designated by the resident for notification in case<br>of an emergency; and,<br>9. Name, address, and telephone number of the<br>health care provider and case manager, if<br>applicable.<br>(b) A copy of the Resident Health Assessment<br>form, AHCA Form 1823 described in rule<br>59A-36.006, F.A.C.<br>(c) Any orders for medications, nursing services,<br>therapeutic diets, _____, or<br>other services to be provided, supervised, or<br>implemented by the facility that require a health<br>care provider's order.<br>(d) Documentation of a resident's refusal of a<br>therapeutic diet pursuant to rule 59A-36.012,<br>F.A.C., if applicable.<br>(e) The resident care record described in<br>paragraph 59A-36.007(1)(e), F.A.C. | A 162               |                                                                                                                          |                          |

Agency for Health Care Administration

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ROSEMONT GARDENS, INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1842 KREIDT DR<br/>ORLANDO, FL 32818</b>                                     |  |                                                        |
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| A 162                                                            | Continued From page 10<br><br>(f) A record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their recorded semi-annually.<br>(g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract.<br>(h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C.<br>(i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C.<br>(j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S.<br>(k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S.<br>(l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for ( ), CF-ES 1006, which is hereby incorporated by reference and available for review at: <a href="http://www.flrules.org/Gateway/reference.asp?No=Ref-04004">http://www.flrules.org/Gateway/reference.asp?No=Ref-04004</a> . The absence of this form will not be the basis for administrative action against a | A 162                                                                          |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966877</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/16/2021</b> |
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**ROSEMONT GARDENS, INC**

**1842 KREIDT DR  
ORLANDO, FL 32818**

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| A 162                    | <p>Continued From page 11</p> <p>facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families.</p> <p>(m) Documentation of the _____ of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable.</p> <p>(n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C.</p> <p>(o) The resident's _____, DH Form 1896, if applicable.</p> <p>(p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility:</p> <ol style="list-style-type: none"> <li>1. A log listing the names of residents participating in this arrangement,</li> <li>2. The resident demographic data required in this paragraph,</li> <li>3. The health assessment described in rule 59A-36.006, F.A.C.,</li> <li>4. The resident's contract described in rule 59A-36.018, F.A.C.; and,</li> <li>5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility.</li> </ol> <p>(q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be</p> | A 162               |                                                                                                                          |                          |

Agency for Health Care Administration

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ROSEMONT GARDENS, INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1842 KREIDT DR<br/>ORLANDO, FL 32818</b>                                     |  |                                                        |
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| A 162                                                            | <p>Continued From page 12</p> <p>provided with a copy of their records upon departure from the facility.</p> <p>(r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on resident record review and interview, the facility failed to obtain semi-annual _____ for 2 of 4 sampled residents (#3 and #4) as required that receives assistance with Activities of Daily Living (ADLs) and assistance with medications.</p> <p>Findings:</p> <p>1. Resident #3's record revealed admission date _____. On the 1823 Health Assessment dated _____ documented medical history of _____, and _____. She need assistance with activities of daily living (ADLs) for ambulation, bathing, _____ toileting and transferring. In further review, the resident needs assistance with self-administration of medications. The last _____ taken was of _____ (pounds) and missing documented evidence of _____ taken in _____ and _____ as required.</p> <p>(Photographic Evidence Obtained)</p> <p>2. Resident #4's record revealed admission date _____. On the 1823 Health Assessment dated _____ documented medical history of _____ type 2, right _____ on 1st and 2nd _____, and _____. He need assistance with ADLs for _____.</p> | A 162                                                                          |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**ROSEMONT GARDENS, INC**

**1842 KREIDT DR  
ORLANDO, FL 32818**

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| A 162                    | Continued From page 13<br><br>bathing and supervision with ambulation, toileting,<br>and transferring. The last _____ recorded on<br>_____ at _____. There was no<br>documentation for _____ for _____ and<br>_____ as required.<br><br>(Photographic Evidence Obtained)<br><br>On _____ at 1:45 PM, an interview with<br>Administrator confirmed the findings.<br><br>Class III                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | A 162               |                                                                                                                          |                          |
| A 181<br>SS=D            | 59A-36.019(2) FAC Emergency Plan Approval<br><br>(2) EMERGENCY PLAN APPROVAL. The plan<br>must be submitted for review and approval to the<br>local emergency management agency.<br>(a) If the local emergency management agency<br>requires revisions to the emergency management<br>plan, such revisions must be made and the plan<br>resubmitted to the local office within 30 days of<br>receiving notification that the plan must be<br>revised.<br>(b) A new facility as described in Rule<br>59A-36.014, F.A.C., and facilities whose<br>ownership has been transferred, must submit an<br>emergency management plan within 30 days<br>after obtaining a license.<br>(c) The facility must review its emergency<br>management plan on an annual basis. Any<br>substantive changes must be submitted to the<br>local emergency agency for review and approval.<br>1. Changes in the name, address, telephone<br>number, or position of staff listed in the plan are<br>not considered substantive revisions for the<br>purposes of this rule.<br>2. Changes in the identification of specific staff<br>must be submitted to the local emergency | A 181               |                                                                                                                          |                          |

Agency for Health Care Administration

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ROSEMONT GARDENS, INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1842 KREIDT DR<br/>ORLANDO, FL 32818</b>                                     |                          |                                                        |
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| A 181                                                            | <p>Continued From page 14</p> <p>management agency annually as a signed and dated addendum that is not subject to review and approval.</p> <p>(d) The local emergency management agency is the final administrative authority for emergency management plans prepared by assisted living facilities.</p> <p>(e) Any plan approved by the local emergency management agency is considered to have met all the criteria and conditions established in this rule.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on facility's records and interview, the facility failed to provide documentation for the last submitted reviewed approval to the local emergency management agency.</p> <p>Findings:</p> <p>Reviewed facility's last Comprehensive Emergency Management Plan (CEMP) submitted and approved</p> <p>(Photographic Evidence Obtained)</p> <p>The Administrator further stated because of her failed fire inspection on . . . . . the Emergency Management agency is pending. There were no other CEMP review dates for 2019 and 2020.</p> <p>On . . . . . at 2:30 PM, at exit interview with Administrator confirmed the finding and further stated that she had no other documented evidence to provide.</p> <p>Class III</p> | A 181                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

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**1842 KREIDT DR  
ORLANDO, FL 32818**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
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| A 200<br>A 200<br>SS=D   | Continued From page 15<br><br>59A-36.025 FAC Emergency Environmental<br>Control<br><br>59A-36.025 Emergency Environmental Control<br>for Assisted Living Facilities.<br>(1) DETAILED EMERGENCY ENVIRONMENTAL<br>CONTROL PLAN. Each assisted living facility<br>shall prepare a detailed plan ("plan") to serve as<br>a supplement to its Comprehensive Emergency<br>Management Plan, to address emergency<br>environmental control in the event of the loss of<br>primary electrical power in that assisted living<br>facility which includes the following information:<br>(a) The acquisition of a sufficient alternate power<br>source such as a generator(s), maintained at the<br>assisted living facility, to ensure that current<br>licensees of assisted living facilities will be<br>equipped to ensure air temperatures will<br>be maintained at or below 81 degrees Fahrenheit<br>for a minimum of ninety-six (96) hours in the<br>event of the loss of primary electrical power.<br>1. The required temperature must be maintained<br>in an area or areas, determined by the assisted<br>living facility, of sufficient size to maintain<br>residents safely at all times and that is<br>appropriate for resident care needs and life safety<br>requirements. For planning purposes, no less<br>than twenty (20) net square per resident<br>must be provided. The assisted living facility may<br>use eighty percent (80%) of its licensed bed<br>capacity as the number of residents to be used in<br>the to determine the required square<br>footage. This may include areas that are less<br>than the entire assisted living facility if the<br>assisted living facility's comprehensive<br>emergency management plan includes allowing a<br>resident to congregate when he or she desires in<br>portions of the building where temperatures will<br>be maintained and includes procedures for | A 200<br><br>A 200  |                                                                                                                          |                          |

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966877</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/16/2021</b> |
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**ROSEMONT GARDENS, INC**

**1842 KREIDT DR  
ORLANDO, FL 32818**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
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| A 200                    | Continued From page 16<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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 | A 200               |                                                                                                                          |                          |

Agency for Health Care Administration

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ROSEMONT GARDENS, INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1842 KREIDT DR<br/>ORLANDO, FL 32818</b>                                     |  |                                                        |
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| A 200                                                            | Continued From page 17<br><br>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.<br>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.<br>(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.<br>1. Facilities must store minimum amounts of fuel onsite as follows:<br>a. A facility with a licensed capacity of 16 beds or less must store 48 hours of fuel onsite.<br>b. A facility with a licensed capacity of 17 or more beds must store 72 hours of fuel onsite.<br>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.<br>3. Piped natural gas is an allowable fuel source and meets the onsite fuel supply requirements under this rule. | A 200                                                                          |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

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| A 200                                                            | <p>Continued From page 18</p> <p>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.</p> <p>(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.</p> <p>(d) The acquisition and maintenance of a monoxide alarm.</p> <p>(2) SUBMISSION OF THE PLAN.</p> <p>(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.</p> <p>(b) Each new assisted living facility shall submit the plan required under this rule prior to obtaining a license.</p> <p>(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.</p> <p>(3) APPROVED PLANS.</p> <p>(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</p> | A 200                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

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| A 200                                                            | <p>Continued From page 19</p> <p>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.</p> <p>(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.</p> <p>(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.</p> <p>(4) IMPLEMENTATION OF THE PLAN.</p> <p>(a) Each assisted living facility licensed prior to the effective date of this rule shall, no later than _____, have implemented the plan required under this rule.</p> <p>(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</p> | A 200                                                                          |                                                                                                                          |                          |                                                        |

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| A 200                                                            | Continued From page 20<br><br>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.<br>(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.<br>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.<br>2. An assisted living facility located in an evacuation zone pursuant to chapter 252, F.S. must either:<br>a. Fully and safely evacuate its residents prior to the arrival of the event; or<br>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.<br>(d) Each new assisted living facility shall implement the plan required under this rule prior to obtaining a license.<br>(e) Existing assisted living facilities that undergo any additions, modifications, alterations, refurbishment, renovations or reconstruction that | A 200                                                                          |                                                                                                                          |  |                                                        |

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| A 200                                                            | <p>Continued From page 21</p> <p>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.</p> <p>(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.</p> <p>(5) POLICIES AND PROCEDURES.</p> <p>(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:</p> <ol style="list-style-type: none"> <li>1. The use of cooling devices and equipment;</li> <li>2. The use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration;</li> <li>3. Wellness checks by assisted living facility staff to monitor for signs of and heat injury; and</li> <li>4. A provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy.</li> </ol> <p>(b) Each assisted living facility shall maintain the written policies and procedures in a manner that makes them readily available at the licensee's</p> | A 200                                                                          |                                                                                                                          |  |                                                        |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ROSEMONT GARDENS, INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1842 KREIDT DR<br/>ORLANDO, FL 32818</b>                                     |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 200                                                            | <p>Continued From page 22</p> <p>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.</p> <p>(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.</p> <p>(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.</p> <p>(7) COMPREHENSIVE EMERGENCY MANAGEMENT PLAN.</p> <p>(a) Assisted living facilities whose comprehensive emergency management plan is to evacuate must comply with this rule.</p> <p>(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.</p> <p>(8) NOTIFICATION.</p> <p>(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:</p> | A 200                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966877</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/16/2021</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**ROSEMONT GARDENS, INC**

**1842 KREIDT DR  
ORLANDO, FL 32818**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
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| A 200                    | <p>Continued From page 23</p> <p>1. Upon submission of the plan to the local emergency management agency that the plan has been submitted for review and approval;</p> <p>2. Upon final implementation of the plan by the assisted living facility.</p> <p>(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.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on observation and interview, the facility failed to ensure that the _____ monoxide detector alarm was operating and working to detect any poison to enter the assisted living facility.</p> <p>Findings:</p> <p>Observation on _____ at 1:30 PM, a box of 6 _____ monoxide detector alarms for each room in the facility was stored, sitting in the corner of the staff office and not operational throughout the facility as required according to the Emergency Power Plan (EPP) written policies.</p> <p>On _____ at 1:45 PM, an interview with the Administrator confirmed the findings. The Administrator stated that she thought you put the _____ monoxide detector alarms up during the hurricane emergency and take them down after.</p> | A 200               |                                                                                                                          |                          |

Agency for Health Care Administration

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|--------------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 200                    | Continued From page 24<br><br>Class III                                                                                      | A 200               |                                                                                                                          |                          |