Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced relicensure, focused control, emergency power plan monitoring and complaint survey for #2020018711 was conducted on through at Elmcroft of Bella Vita, an assisted living facility in Venice, Florida. Complaint # 2020018711 was substantiated at A0030. The following is a description of the deficiencies.	A 000		
A 028	59A-36.007(4) FAC Resident Care - Activities of Daily Living (4) ACTIVITIES OF DAILY LIVING. Facilities must offer supervision of or assistance with activities of daily living as needed by each resident. Residents should be encouraged to be as independent as possible in performing activities of daily living. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to offer supervision or assistance with activities of daily living (ADL) as needed for 2 (Resident #6 and #11) of 3 residents reviewed requiring assistance with ADL's. The findings included: Record review of Resident #11's file revealed a Health Assessment Form 1823 (1823) dated which indicated she was a precaution, needed assistance with bathing and supervision with ambulation, , toileting and transferring. On at 10:45 a.m., Resident #11's friend	A 028		

AHCA Form 3020-0001

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 028	Continued From page 1 said Resident #11 pays for the package to get a bath twice a week. Her shower days were Tuesdays and Saturdays. She said Resident #11 did not get her Tuesday or Saturday bath that week. She said she spoke with the facility staff the day prior (Sunday) and she finally got her Saturday bath on Sunday. The friend said she realized the facility was short staffed, but Resident #11 was elderly and needed assistance with bathing because she had and was unable to move well enough to reach everything. On . . . . . at 12:15 p.m., Resident #11 said she had not been getting her showers and she did not know why. She said she needed help from the bathroom also and they didn't seem to come when she needed help. Record review of Resident #6's file revealed a Health Assessment Form 1823 (1823) dated . . . . . which indicated she needed supervision assistance with bathing, toileting and transferring. On at 12:01 p.m., Resident #6 said the facility had had not been providing her showers consistently. Resident #6 admitted there had been times she refused, but that was because the caregiver had been a man, and she preferred her showers by a woman. She said she had spoken with the Director of Nursing (DON) and management and told them she would be willing to take her shower at any time of the day, yet they continued to miss giving her showers. On . . . at 1:25 p.m., the Director of Nursing (DON) said the aides were supposed to document the showers and if someone refused there were choices to indicate why the resident refused. The DON admitted he had received resident complaints about not getting showers	A 028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 028	Continued From page 2 and the facility had been having staffing issues. He said he had previously spoke with Resident #6 about missed showers but said he did not know Resident #6 preferred a female caregiver. The DON said the showers were on a schedule and if someone refused, they weren't offered another shower until their next scheduled shower. Bathing logs were requested from the DON for Resident #6 and Resident #11 at this time. On . . . . at 2:45 p.m., bathing logs had still not been provided and were requested from the DON again. On . . . . . at 10:24 a.m., bathing logs had still not been provided and were requested from the Executive Director. The Executive Director said they did not keep a log of ADLs. At this time a discussion ensued there was conflicting information from the DON who said they were supposed to maintain a log. The Executive Director said if there was a log, it would be fair to say they were not documenting it. On . . . . . at 11:21 a.m., the Executive Director said she did not have a bathing log for Resident #11 as Resident #11 was independent. Discussion ensued that Resident #11 was , ... and her 1823 indicated she needed assistance with bathing. The Executive Director said there must have been an error and will have it adjusted. On 11:21 a.m., the Executive Director provided a bathing log for Resident #6 dating to . This log revealed Resident #6 refused a shower on . . . . . There was no reason documented why she refused. The next documented shower was 6 days later on . The next documented shower was 5 days later on	A 028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 028	Continued From page 3 . . . . . Showers were then documented for , , . The next shower was documented 6 days later on . . . . . The next shower was documented 5 days later on . The next entry was . . . and simply read activity did not occur. There was no explanation why it did not occur. The next entry was for and said refused. There was no documentation why she refused. The next entry documented a shower on . The next two entries were for . . . and . . . . which documented Resident #6 refused with no explanation of why she refused. The next shower was documented for , which was a 2 week gap from her last documented shower. On . . . . . at 1:13 p.m., the Executive Director said she had misspoken. She said Resident #11 was supposed to get shower assistance twice a week, but when the aides went in the computer, it was supposed to light up and it wasn't, so they weren't documenting on her. The Executive Director said they didn't have the time to document. The Executive Director said both Resident #6 and Resident #11 are . . . . . at a level of service to be showered twice a week. On at 3:00 p.m., the Executive Director said the DON was new to the facility and they would begin working on documentation, ensuring the residents get the care they needed and improving staffing. Class III	A 028		
A 030	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 4 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; [illegible] Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- [illegible] or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage;	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 5 4. Resident elopement; 5. Reporting resident , neglect, and ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 6 guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 7 regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 8 jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without . . . . . , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, . . . , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, . Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and . . . . . , Rights	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 9 Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated [illegible] or [illegible] under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review and resident and staff interview, the facility failed to honor a resident's right to choose to use an assistive device to assist with bed mobility, transferring and safety for 1 (Resident #6) of 1 resident reviewed for use of a bed rail. The findings included: On [redacted] at 12:00 p.m., Resident #6 was observed lying down in bed. She had a straight [redacted] chair shoved up to the side of the bed. On [redacted] at 12:01 p.m., Resident #6 said she had used a bed rail for years. She said several months ago, the facility staff came in and took her bed rail off. Resident #6 said they told her they	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 10 would order a . . . (type of equipment to assist with mobility & transferring), but when they tried it, the . . didn't fit her bed. She said after they tried the , they did not return her bed rail. Resident #6 said shortly after they removed her bed rail, she out of bed and ended up with a large . . . on her . . . She said if she'd had her bed rail, she could have used that to get up. Resident #6 said since they took her bed rail away, they put a chair next to her bed, but she felt it was no help and in fact felt it could be dangerous if it moved when she tried to use it to get up. Resident #6 said she has talked to the Administrator about it, and that she had an order for a bed rail but apparently it got "lost". Resident #6 said her doctor was just in and ordered it again, but she still didn't have the bed rail . . . . Review of Resident #6's progress notes revealed the following notes: side rail removed from bed due to policy. Resident aware of policy. Daughter called on video chat and aware of removal. . . . . spoke with residents' daughter ok'd $325 fee for to be added to rent. . . . Resident #6 slid out of bed, small . . . . . to right . Supervisor, Doctor & family notified. No other injuries. Did not hit . . . . Review of Resident #6's file revealed no further documentation regarding the bed rail or the . There was no documentation the . . had been received, that it had been placed/installed on the resident's bed, whether it fit the resident's bed or whether use of the device was successful. On at 1:49 p.m., the Executive Director said Resident #6 and her daughter had emailed her about the bedrail. The Executive Director admitted the physician did order a bed rail, but their company policy does not allow bed rails.	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 11 The Executive Director said they did try a , but it did not fit Resident #6's bed. She said nothing else had been tried as their policy is no bedrails. The Executive Director said she did not know if Resident #6 has out of bed. On at 1:56 p.m., in a telephone call, the nurse at Resident #6's primary care doctor's office said they had talked with Resident #6 and had ordered a bed rail. She said they had talked with the DON and were waiting for the DON to call them and tell them what the order needed to say. On at 2:04 p.m., the DON said the original order did come to him as a bed rail. The DON said he got rid of the order because he thought we were going with a . He said their policy does not allow bed rails. The DON said he was not aware they had already tried a for Resident #6. Review of the facility policy titled Bed Safety, Policy Reference 3024, effective date: reads: Quarter bed rails may only be used if state regulations permit and upon receiving a physicians order for use and the community team has determined no other intervention or device was successful: the resident requires the need for quarter bed rails for mobility and transferring purposes only and Resident Service Director/designee has gained approval from Regional Director of Operations and Regional Director of Quality Services. On at 3:00 p.m., the Executive Director said she may have misinterpreted the policy. She said she would replace the bedrail and discuss with corporate.	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _______ B. WING _______	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 12 Class III	A 030		
A 050	429.256(2) FS;59A-36.008(1) FAC Medication - Self Administered Medications 429.256(2) Residents who are capable of self-administering their own medications without assistance shall be encouraged and allowed to do so. However, an unlicensed person may, consistent with a dispensed prescription ' s label or the package directions of an over-the-counter medication, assist a resident whose condition is medically stable with the self-administration of routine, regularly scheduled medications that are intended to be self-administered. Assistance with self-medication by an unlicensed person may occur only upon a documented request by, and the written informed consent of, a resident or the resident ' s surrogate, guardian, or attorney in fact. For the purposes of this section, self-administered medications include both legend and over-the-counter oral dosage forms, [illegible] dosage forms, [illegible] patches, and [illegible], and [illegible] dosage forms including solutions, suspensions, sprays, and inhalers. 59A-36.008 Pursuant to sections 429.255 and 429.256, F.S., and this rule, licensed facilities may assist with the self-administration or administration of medications to residents in a facility. A resident may not be compelled to take medications but may be counseled in accordance with this rule. (1) SELF ADMINISTERED MEDICATIONS. (a) Residents who are capable of self-administering their medications without assistance must be encouraged and allowed to	A 050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 050	Continued From page 13 do so. (b) If facility staff observes health changes that could reasonably be attributed to the improper self-administration of medication, staff must consult with the resident concerning any problems the resident may be experiencing in self-administering the medications. The consultation should describe the services offered by the facility that aid the resident with medication administration through the use of a pill organizer, through providing assistance with self-administration of medications, or through administering medications. The facility must contact the resident's health care provider when observable health changes occur that may be attributed to the resident's medications. The facility must document such contacts in the resident's records. This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the facility resident contract or facility brochure contained all the required information to meet the requirements for informed consent for unlicensed personnel to assist with self-administration of medications. The findings included: On . . . at 10:40 a.m., during observation of medication pass, performed by Medication Technician (Med Tech) Staff C, assistance with self-administration of medication was observed for multiple residents. Staff C stated she is a certified Med Tech. Record review of Resident #11's file revealed there was no informed consent for unlicensed staff to assist with medications. On . . at	A 050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 050	Continued From page 14 9:48 a.m., the Administrator stated when the facility did new contracts, the clause was somehow left off. Review of the facility brochure and facility resident contracts revealed no documentation for written informed consent for assistance with self-administration of medications by unlicensed personnel, for notification to residents, residents surrogate or guardians. On at 11:56 a.m., during an interview with the Executive Director, stated the facility always used med techs to assist with medications, and there should be informed consents signed by or for the residents allowing unlicensed personnel to assist with self-administration of their medications. She confirmed there is no informed consent documentation within the facility contracts. Class III	A 050		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ830	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider	CZ830		

AHCA Form 3020-0001

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

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ830	Continued From page 1 is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) The agency may adopt rules relating to emergency management planning, communications, and operations. Licensees	CZ830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ830	Continued From page 2 providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to submit annually and maintain documentation of a current Comprehensive Emergency Management Plan (CEMP), and Emergency Power Plan (EPP) approved by the local emergency management agency to ensure the safety and welfare of all residents. The findings included: On the Executive Director provided an Emergency Power Plan (EPP) that had been completed on by the previous Executive Director, she also provided an approval letter date . The letter indicated the EPP must be included in the annual Comprehensive Emergency Management Plan (CEMP) submission as an annex/addendum. On at 2:41 p.m., the Executive Director said she took over the position in , she confirmed she did not complete nor submit an updated EPP with the changes showing her as the new Executive Director for the facility. Review of the facility's CEMP showed it had been approved on . The letter further indicated the facility's CEMP plan is approved for 12 months from the date of the letter. On at 9:20 a.m., the Executive Director said she checked the emergency management agency portal and it revealed that her CEMP was	CZ830		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ830	Continued From page 3 past due, she confirmed she never submitted the CEMP/EPP for the 2020 year. Class III	CZ830		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced relicensure, focused control, emergency power plan monitoring and complaint survey for #2020018711 was conducted on through at Elmcroft of Bella Vita, an assisted living facility in Venice, Florida. Complaint # 2020018711 was substantiated at A0030. The following is a description of the deficiencies.	A 000		
A 028	59A-36.007(4) FAC Resident Care - Activities of Daily Living (4) ACTIVITIES OF DAILY LIVING. Facilities must offer supervision of or assistance with activities of daily living as needed by each resident. Residents should be encouraged to be as independent as possible in performing activities of daily living. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to offer supervision or assistance with activities of daily living (ADL) as needed for 2 (Resident #6 and #11) of 3 residents reviewed requiring assistance with ADL's. The findings included: Record review of Resident #11's file revealed a Health Assessment Form 1823 (1823) dated which indicated she was a precaution, needed assistance with bathing and supervision with ambulation, , toileting and transferring. On at 10:45 a.m., Resident #11's friend	A 028		

AHCA Form 3020-0001

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 028	Continued From page 1 said Resident #11 pays for the package to get a bath twice a week. Her shower days were Tuesdays and Saturdays. She said Resident #11 did not get her Tuesday or Saturday bath that week. She said she spoke with the facility staff the day prior (Sunday) and she finally got her Saturday bath on Sunday. The friend said she realized the facility was short staffed, but Resident #11 was elderly and needed assistance with bathing because she had and was unable to move well enough to reach everything. On . . . . . at 12:15 p.m., Resident #11 said she had not been getting her showers and she did not know why. She said she needed help from the bathroom also and they didn't seem to come when she needed help. Record review of Resident #6's file revealed a Health Assessment Form 1823 (1823) dated . . . . . which indicated she needed supervision assistance with bathing, toileting and transferring. On at 12:01 p.m., Resident #6 said the facility had had not been providing her showers consistently. Resident #6 admitted there had been times she refused, but that was because the caregiver had been a man, and she preferred her showers by a woman. She said she had spoken with the Director of Nursing (DON) and management and told them she would be willing to take her shower at any time of the day, yet they continued to miss giving her showers. On . . . at 1:25 p.m., the Director of Nursing (DON) said the aides were supposed to document the showers and if someone refused there were choices to indicate why the resident refused. The DON admitted he had received resident complaints about not getting showers	A 028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 028	Continued From page 2 and the facility had been having staffing issues. He said he had previously spoke with Resident #6 about missed showers but said he did not know Resident #6 preferred a female caregiver. The DON said the showers were on a schedule and if someone refused, they weren't offered another shower until their next scheduled shower. Bathing logs were requested from the DON for Resident #6 and Resident #11 at this time. On . . . . at 2:45 p.m., bathing logs had still not been provided and were requested from the DON again. On . . . . . at 10:24 a.m., bathing logs had still not been provided and were requested from the Executive Director. The Executive Director said they did not keep a log of ADLs. At this time a discussion ensued there was conflicting information from the DON who said they were supposed to maintain a log. The Executive Director said if there was a log, it would be fair to say they were not documenting it. On . . . . . at 11:21 a.m., the Executive Director said she did not have a bathing log for Resident #11 as Resident #11 was independent. Discussion ensued that Resident #11 was , ... and her 1823 indicated she needed assistance with bathing. The Executive Director said there must have been an error and will have it adjusted. On 11:21 a.m., the Executive Director provided a bathing log for Resident #6 dating to . This log revealed Resident #6 refused a shower on . . . . . There was no reason documented why she refused. The next documented shower was 6 days later on . The next documented shower was 5 days later on	A 028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 028	Continued From page 3 . . . . . Showers were then documented for , , . The next shower was documented 6 days later on . . . . . The next shower was documented 5 days later on . The next entry was . . . and simply read activity did not occur. There was no explanation why it did not occur. The next entry was for and said refused. There was no documentation why she refused. The next entry documented a shower on . The next two entries were for . . . and . . . . which documented Resident #6 refused with no explanation of why she refused. The next shower was documented for , which was a 2 week gap from her last documented shower. On . . . . . at 1:13 p.m., the Executive Director said she had misspoken. She said Resident #11 was supposed to get shower assistance twice a week, but when the aides went in the computer, it was supposed to light up and it wasn't, so they weren't documenting on her. The Executive Director said they didn't have the time to document. The Executive Director said both Resident #6 and Resident #11 are . . . . . at a level of service to be showered twice a week. On at 3:00 p.m., the Executive Director said the DON was new to the facility and they would begin working on documentation, ensuring the residents get the care they needed and improving staffing. Class III	A 028		
A 030	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 4 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; [illegible] Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- [illegible] or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage;	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 5 4. Resident elopement; 5. Reporting resident , neglect, and ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 6 guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 7 regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 8 jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without . . . . . , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, . . . , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, . Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and . . . . . , Rights	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 9 Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated [illegible] or [illegible] under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review and resident and staff interview, the facility failed to honor a resident's right to choose to use an assistive device to assist with bed mobility, transferring and safety for 1 (Resident #6) of 1 resident reviewed for use of a bed rail. The findings included: On [redacted] at 12:00 p.m., Resident #6 was observed lying down in bed. She had a straight [redacted] chair shoved up to the side of the bed. On [redacted] at 12:01 p.m., Resident #6 said she had used a bed rail for years. She said several months ago, the facility staff came in and took her bed rail off. Resident #6 said they told her they	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 10 would order a . . . (type of equipment to assist with mobility & transferring), but when they tried it, the . . didn't fit her bed. She said after they tried the , they did not return her bed rail. Resident #6 said shortly after they removed her bed rail, she out of bed and ended up with a large . . . on her . . . She said if she'd had her bed rail, she could have used that to get up. Resident #6 said since they took her bed rail away, they put a chair next to her bed, but she felt it was no help and in fact felt it could be dangerous if it moved when she tried to use it to get up. Resident #6 said she has talked to the Administrator about it, and that she had an order for a bed rail but apparently it got "lost". Resident #6 said her doctor was just in and ordered it again, but she still didn't have the bed rail . . . . Review of Resident #6's progress notes revealed the following notes: side rail removed from bed due to policy. Resident aware of policy. Daughter called on video chat and aware of removal. . . . . spoke with residents' daughter ok'd $325 fee for to be added to rent. . . . Resident #6 slid out of bed, small . . . . . to right . Supervisor, Doctor & family notified. No other injuries. Did not hit . . . . Review of Resident #6's file revealed no further documentation regarding the bed rail or the . There was no documentation the . . had been received, that it had been placed/installed on the resident's bed, whether it fit the resident's bed or whether use of the device was successful. On at 1:49 p.m., the Executive Director said Resident #6 and her daughter had emailed her about the bedrail. The Executive Director admitted the physician did order a bed rail, but their company policy does not allow bed rails.	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 11 The Executive Director said they did try a , but it did not fit Resident #6's bed. She said nothing else had been tried as their policy is no bedrails. The Executive Director said she did not know if Resident #6 has out of bed. On at 1:56 p.m., in a telephone call, the nurse at Resident #6's primary care doctor's office said they had talked with Resident #6 and had ordered a bed rail. She said they had talked with the DON and were waiting for the DON to call them and tell them what the order needed to say. On at 2:04 p.m., the DON said the original order did come to him as a bed rail. The DON said he got rid of the order because he thought we were going with a . He said their policy does not allow bed rails. The DON said he was not aware they had already tried a for Resident #6. Review of the facility policy titled Bed Safety, Policy Reference 3024, effective date: reads: Quarter bed rails may only be used if state regulations permit and upon receiving a physicians order for use and the community team has determined no other intervention or device was successful: the resident requires the need for quarter bed rails for mobility and transferring purposes only and Resident Service Director/designee has gained approval from Regional Director of Operations and Regional Director of Quality Services. On at 3:00 p.m., the Executive Director said she may have misinterpreted the policy. She said she would replace the bedrail and discuss with corporate.	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: ______ B. WING ______	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 12 Class III	A 030		
A 050	429.256(2) FS;59A-36.008(1) FAC Medication - Self Administered Medications 429.256(2) Residents who are capable of self-administering their own medications without assistance shall be encouraged and allowed to do so. However, an unlicensed person may, consistent with a dispensed prescription ' s label or the package directions of an over-the-counter medication, assist a resident whose condition is medically stable with the self-administration of routine, regularly scheduled medications that are intended to be self-administered. Assistance with self-medication by an unlicensed person may occur only upon a documented request by, and the written informed consent of, a resident or the resident ' s surrogate, guardian, or attorney in fact. For the purposes of this section, self-administered medications include both legend and over-the-counter oral dosage forms, , dosage forms, patches, and , , , , and dosage forms including solutions, suspensions, sprays, and inhalers. 59A-36.008 Pursuant to sections 429.255 and 429.256, F.S., and this rule, licensed facilities may assist with the self-administration or administration of medications to residents in a facility. A resident may not be compelled to take medications but may be counseled in accordance with this rule. (1) SELF ADMINISTERED MEDICATIONS. (a) Residents who are capable of self-administering their medications without assistance must be encouraged and allowed to	A 050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 050	Continued From page 13 do so. (b) If facility staff observes health changes that could reasonably be attributed to the improper self-administration of medication, staff must consult with the resident concerning any problems the resident may be experiencing in self-administering the medications. The consultation should describe the services offered by the facility that aid the resident with medication administration through the use of a pill organizer, through providing assistance with self-administration of medications, or through administering medications. The facility must contact the resident's health care provider when observable health changes occur that may be attributed to the resident's medications. The facility must document such contacts in the resident's records. This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the facility resident contract or facility brochure contained all the required information to meet the requirements for informed consent for unlicensed personnel to assist with self-administration of medications. The findings included: On . . . at 10:40 a.m., during observation of medication pass, performed by Medication Technician (Med Tech) Staff C, assistance with self-administration of medication was observed for multiple residents. Staff C stated she is a certified Med Tech. Record review of Resident #11's file revealed there was no informed consent for unlicensed staff to assist with medications. On . . at	A 050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963725	A. BUILDING: _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF BELLA VITA	1420 EAST VENICE AVENUE VENICE, FL 34292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 050	Continued From page 14 9:48 a.m., the Administrator stated when the facility did new contracts, the clause was somehow left off. Review of the facility brochure and facility resident contracts revealed no documentation for written informed consent for assistance with self-administration of medications by unlicensed personnel, for notification to residents, residents surrogate or guardians. On at 11:56 a.m., during an interview with the Executive Director, stated the facility always used med techs to assist with medications, and there should be informed consents signed by or for the residents allowing unlicensed personnel to assist with self-administration of their medications. She confirmed there is no informed consent documentation within the facility contracts. Class III	A 050		