Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11942866	A. BUILDING: _____ B. WING _____	R 04/27/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{CZ814}	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12(2) Care Provider Background Screening Clearinghouse.- (b) Until such time as the [illegible] are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [illegible] submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; [illegible]; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review, and staff interview, the facility failed to maintain the employment status of all employees within the clearinghouse and report any changes of status within 10 business days on the employee roster for 2 (Staff T and Staff U) of 9 files reviewed. This is an uncorrected deficiency.	{CZ814}		

AHCA Form 3020-0001

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

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{CZ814}	Continued From page 1 The findings included: Review of the employee records for Staff T revealed a hire date of . Staff T was not listed on the employee roster and his background screening showed he was not eligible for employment. Staff T had been working steadily as a medication technician in the facility and last worked on . Record review revealed Staff U was hired as a resident aide. Review of the Agency's clearing house employee roster revealed Staff U was added on the clearinghouse roster on with a background screening that was "in process" (not eligible for employment) up to and including . Staff U has been working steadily in the facility and last worked on before survey. On at 3:15 p.m., in an interview, the Administrator stated he thought there was a probationary period allowed where new employees could work before being added to the clearinghouse. He said he gets busy. and he forgets to add the employees and they were added late. Unclassified .	{CZ814}		
{CZ815}	408.809; 435.02(2); 435.06 FS Background Screening; Prohibited Offenses 408.809 Background screening; prohibited offenses.- (1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are	{CZ815}		

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{CZ815}	Continued From page 2 considered employees for the purposes of conducting screening under chapter 435: (a) The licensee, if an individual. (b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider. (c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider. (d) Any person who is a controlling interest. (e) Any person, as required by authorizing statutes, seeking employment with a licensee or provider who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, ␣ with a licensee or provider whose responsibilities require him or her to provide personal care or personal services directly to clients, or ␣ with a licensee or provider to work 20 hours a week or more who will have access to client funds, personal property, or living areas. Evidence of contractor screening may be retained by the contractor's employer or the licensee. (3) All ␣ must be provided in electronic format. Screening results shall be reviewed by the agency with respect to the offenses specified in s. 435.04 and this section, and the qualifying or disqualifying status of the person named in the request shall be maintained in a database. The qualifying or disqualifying status of the person named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee's behalf. (4) In addition to the offenses listed in s. 435.04,	{CZ815}		

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{CZ815}	Continued From page 3 all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an . . . . awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction: (a) Any authorizing statutes, if the offense was a felony. (b) This chapter, if the offense was a felony. (c) Section 409.920, relating to Medicaid provider fraud. (d) Section 409.9201, relating to Medicaid fraud. (e) Section 741.28, relating to domestic violence. (f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection. (g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems. (h) Section 817.234, relating to false and fraudulent insurance claims. (i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony. (j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider. (k) Section 817.505, relating to patient brokering. (l) Section 817.568, relating to criminal use of personal identification information. (m) Section 817.60, relating to obtaining a credit card through fraudulent means. (n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony. (o) Section 831.01, relating to forgery.	{CZ815}		

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{CZ815}	Continued From page 4 (p) Section 831.02, relating to uttering forged instruments. (q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes. (r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes. (s) Section 831.30, relating to fraud in obtaining medicinal drugs. (t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony. (u) Section 895.03, relating to racketeering and collection of unlawful debts. (v) Section 896.101, relating to the Florida Money Laundering Act. If, upon rescreening, a person who is currently employed or . . . . . with a licensee and was screened and qualified under s. 435.04 has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency no later than 30 days after receipt of the rescreening results by the person. (5) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The Department of Law Enforcement shall charge the	{CZ815}		

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{CZ815}	Continued From page 5	{CZ815}		

agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening.
(6)(a) As provided in chapter 435, the agency may grant an exemption from disqualification to a person who is subject to this section and who:
1. Does not have an active professional license or certification from the Department of Health; or
2. Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification.
(b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may grant an exemption from disqualification to a person who is subject to this section and who has received a professional license or certification from the Department of Health or a regulatory board within that department and that person is providing a service within the scope of his or her licensed or certified practice.
(7) The agency and the Department of Health may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, chapter 435, and authorizing statutes requiring background screening and to implement and adopt criteria relating to retaining ⎵ , pursuant to s. 943.05(2).
(8) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this section, terminates the person against whom the report was issued, whether or not that person has filed for an exemption with the Department of Health or the agency.

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{CZ815}	Continued From page 6 435.06 Exclusion from employment.- (1) If an employer or agency has reasonable cause to believe that grounds exist for the denial or termination of employment of any employee as a result of background screening, it shall notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity. (2)(a) An employer may not hire, select, or otherwise allow an employee to have contact with any person that would place the employee in a role that requires background screening until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of employment. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select, or otherwise allow the employee to have contact with any person that would place the employee in a role that requires background screening unless the employee is granted an exemption for the disqualification by the agency as provided under s. 435.07. (b) If an employer becomes aware that an employee has been for a disqualifying offense, the employer must remove the employee from contact with any person that places the employee in a role that requires background screening until the is resolved in a way that the employer determines that the employee is still eligible for employment under this chapter. (c) The employer must terminate the employment of any of its personnel found to be in	{CZ815}		

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{CZ815}	Continued From page 7	{CZ815}		

noncompliance with the minimum standards of this chapter or place the employee in a position for which background screening is not required unless the employee is granted an exemption from disqualification pursuant to s. 435.07.
(d) An employer may hire an employee to a position that requires background screening before the employee completes the screening process for training and orientation purposes. However, the employee may not have direct contact with persons until the screening process is completed and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment.
(3) Any employee who refuses to cooperate in such screening or refuses to timely submit the information necessary to complete the screening, including , if required, must be disqualified for employment in such position or, if employed, must be dismissed.
(4) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages against, an employer that, upon notice of a conviction or for a disqualifying offense listed under this chapter, terminates the person against whom the report was issued or who was , regardless of whether or not that person has filed for an exemption pursuant to this chapter.

435.02 Definitions.-For the purposes of this chapter, the term:
(2) "Employee" means any person required by law to be screened pursuant to this chapter, including, but not limited to, persons who are contractors, licensees, or volunteers.

This Statute or Rule is not met as evidenced by:

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{CZ815}	Continued From page 8 Based on record review, and staff interview, the facility failed to ensure all employees who provide direct care or have contact with residents or their personal belongings were screened and found eligible for employment prior to resident contact for 2 (Staff T and Staff U) of 9 files reviewed. This is an uncorrected deficiency. The findings included: Review of the employee records for Staff T revealed a hire date of . Staff T was not listed on the employee roster and he was not eligible for employment. Staff T had been working steadily in the facility. Record review revealed Staff U was hired . . . . . as a resident aide. Review of the Agency's clearinghouse employee roster revealed Staff E was added to the clearinghouse roster on with a background screening that was in process up to and including . Staff U had been working steadily in the facility. On . . . . . at 3:15 p.m., the Administrator said he thought there was a probationary period allowed where new employees could work before being added to the clearinghouse, and when he gets busy he forgets to add the employees and they were added late. Unclassified .	{CZ815}		

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

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{A 025}	Continued From page 1 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review, and staff and resident interview, the facility failed to provide care and services appropriate to the needs of residents and maintain a general awareness of the residents' whereabouts for 1 (Resident #20) of 1 resident reviewed for elopement. The facility failed to notify the Advance Registered Nurse	{A 025}		

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{A 025}	Continued From page 2 Practitioners of Resident #20's elopements and growing refusal of medications. This is an uncorrected deficiency. The findings included: 1. Review of the facility's adverse incident reports revealed Resident #20 had eloped from the facility on [redacted] at 2:59 p.m. The facility's administrator filed a Day 1 Adverse Incident Report because of police involvement and wrote in circumstances of the incident that the resident who had a diagnosis of [redacted], went to the corner store about 3 p.m. He said she was observed acting strangely and the sheriff was called by the store employees. The sheriff brought the resident [redacted] to the facility. No Day 15 Adverse Incident Report was completed for this incident, even though the store was 1 mile down the road from the facility and the resident needed to cross a busy intersection. Resident #20's Health Assessment Agency Form 1823 dated [redacted] indicated she had a diagnosis of [redacted] and [redacted] which she is on [redacted] medication for. Review of Resident #20's Observation Log revealed the following: [redacted] - Resident #20 was sitting out front on the bench and decided to walk to the store down the road and was returned by sheriff's office. Another entry that was not logged with the date or time said: "Last night Resident #20 was up yelling in the halls in the middle of the night, walking the halls naked at 4 a.m. in the morning and waking peoples up. And walks around being crazy and she is not eating." This note was written by	{A 025}		

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{A 025}	Continued From page 3 Medication Technician (Med Tech) Staff H. 2. Review of Resident #20's Medication Observation Record (MOR) revealed she had been refusing more and more of her medication for the last three months. Resident #20 was refusing most of her medication starting on , a few days after she had eloped and walked away from the facility. In the month of , the resident refused the following medications without evidence the doctor was notified: 5 milligrams (mg) -for high and - refused 16 times. Baby 81 mg for maintenance - refused 17 times. 20 mg for hyper - refused 17 times. 600 mg & D3 20 meq - refused 17 times. 100 mcg/5mcg inhaler for - refused 34 times. 10 mg for - refused 37 times. 10 mg for high - refused 16 times. tart 25 mg for high & - refused 10 times. 40 mg for decreasing - refused 18 times. On at 11:25 a.m., an interview was attempted with Resident #20 who opened her door and stood staring at the surveyor. The resident declined to be interviewed or allow the surveyor into her room. The resident answered yes or no but had a flat affect. The resident was observed to be dressed appropriately for the time of day and her room appeared clean. The blinds	{A 025}		

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{A 025}	Continued From page 4 were closed, and the room was shaded. On [redacted] at 11:35 a.m., in an interview, Activities/Med Tech Staff H said Resident #20 had been acting bizarre for a while now. She admitted she was the one who wrote the note about the resident yelling naked in the hallway on nights. She said it happened in the first couple of weeks in [redacted] of this year. She said the resident was in a different room at the time with a roommate and she would do strange things to her. Staff H said Resident #20 would flush her roommate's stuff down the toilet and act strange. The facility had to move Resident #20 after that. Staff H said she came to work one morning around 5:30 a.m. and found Resident #20 out in the bushes out front of the facility. When she asked her what she was doing out there she said getting fresh air. She said this incident happened a few days before the incident when the resident walked away from the facility and was found at the grocery store down the road. Staff H said the resident is refusing her medications and when she comes to her room the resident just stands and stares at her and blinks her [redacted] rapidly but does not say a word. She said she feels the resident has issues. She reported she has told the Advanced Registered Nurse Practitioner (ARNP) who comes to see her about the behavior, but she only sees her for a few minutes and leaves. On [redacted] at 12:26 p.m., in an interview, Med Tech Staff L said Resident #20 had been acting strangely and she was refusing her medication almost all the time. She was not only refusing her [redacted] (psych) medication but most of the other medication too. She says the psych medication makes her feel fuzzy in the [redacted] and she does not want it. The med tech said the	{A 025}		

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{A 025}	Continued From page 5	{A 025}		

resident will come to the medication room and say what she will take and will not take the rest. Staff L said she has told the psych ARNP but nothing had changed. She said she tried to educate the resident on the reason for the medication so she knows she should be taking them for her health, but she still refuses.

On ..... at 12:50 p.m., in an interview, Med Tech Supervisor Staff M said when Resident #20 had been refusing her psych medication . . . the psych ARNP was aware.

On at 1:19 p.m., in an interview, the Administrator said Resident #20 was sitting out front of the facility on a bench on the day she walked away from the facility last month. He said she could sit out front if the secretary kept an , on her. He said he reported it as an adverse incident because the sheriff had brought the resident . . . to the facility after being found at the grocery store down the street acting strangely. He said he did not classify it as an elopement. When asked if he had done a follow-up investigation after, he said whatever was in the adverse incident was all he thought he had to do. The Administrator said he had no documentation of re-training. He said it was not normal for the resident to walk away from the facility and he was keeping an , on her. When asked how he keeps an , on her he did not have an answer.

at 9:55 a.m., in an interview, Psych ARNP Staff V said she saw the resident a couple of weeks ago on and she was not informed at the time about the behaviors and resident elopement on . She said she was also unaware of Resident #20 being found outdoors at 5 a.m. in the bushes or about the screaming in

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{A 025}	Continued From page 6 the hallways at 4 a.m. naked. She also said she was unaware of Resident #20 refusing her other medication for other medical conditions like her , , and . The ARNP said she was not aware Resident #20 had gone to the emergency room (ER) on for lower . . . . The ARNP said Resident #20 is not safe to be outdoors or leave the facility unsupervised. She said Resident #20 can be unpredictable due to her diagnosis. On at 12:15 p.m., in an interview, ARNP Staff W said she was unaware of Resident #20's elopement last month. She said she was aware "generally" the resident had been refusing her medication over the last couple of months but was not aware of what medication and how much. The ARNP said the resident would be safe here if the facility followed safety protocol and monitored people, alarms and doors being secured. She said she has seen the resident a few times in the last month. She said the resident is not safe to leave the facility unsupervised because of her diagnosis of . . . . . and . , . . . On at 1:30 p.m., Resident #20 was seen walking about the facility. The front doors to the facility were open and no one was present at the front desk to make observations of who comes and goes through the front doors. At the time of the survey, several front office workers were off, and no one was stationed at the front desk or office. Class II .	{A 025}		

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{A 030}	Continued From page 7	{A 030}		
{A 030}	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the	{A 030}		

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{A 030}	Continued From page 8 facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the 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	{A 030}		

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{A 030}	Continued From page 9 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of 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.	{A 030}		

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{A 030}	Continued From page 10 (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , ,

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{A 030}	Continued From page 11	{A 030}		

telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.
(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.
(2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a 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

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{A 030}	Continued From page 12 call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder [illegible] Hotline operated by the Department of Children and Families, and [illegible], Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated [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 observation, record review, and staff and resident interview, the facility failed to ensure Residents' Rights to live in a safe, decent living environment free from [illegible] and neglect for 3 (Residents #7, #20 & #21) of 3 residents reviewed for adverse incidents. The facility continued to employed staff who were not eligible, came to work under the influence of [illegible] and failed to perform their duties effectively leaving residents unsupervised and unassisted for 2 (Staff T and U) of 9 staff reviewed. The facility failed to hire adequate staff to ensure	{A 030}		

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{A 030}	Continued From page 13 a clean environment. The facility also failed to safeguard residents' well-being by failing to follow current control standards related to COVID-19 recommendations set forth by Centers for Control and Prevention (CDC). Refer to https://www.cdc.gov/coronavirus/2019-ncov/hcp/assisted-living.html. This is an uncorrected deficiency. The findings included: 1. On review of facility's Adverse Incident Reports since the last survey the following was discovered: A. Incident date - an event reported to law enforcement for investigation. Resident #7 reported $17 dollars missing from her wallet. Police were called and the incident was reported to AHCA, but no investigation or analysis of the incident was done by the Administrator or his staff. No Education was done for current staff on , neglect, and . B. Incident date - an event reported to law enforcement for investigation. Resident #21 called the sheriff's office and reported $400 money missing. Police came after the resident called them and the incident was reported to AHCA, but no investigation or analysis of the incident was done by the Administrator or his staff. No education was done for staff on , neglect, and . The Administrator had signed off as being complete on . C. Incident date - an event reported to law enforcement for investigation. Resident #20 diagnosed with & went to the corner store about 3:00 p.m. on . She was observed to be acting strange and the sheriff was called by store personnel. The sheriff brought Resident #20 to the	{A 030}		

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{A 030}	Continued From page 14 facility. Staff were unaware that she was missing until the sheriff brought her . On at 1:23 p.m., in an interview, the Administrator said he was not aware he had to do any investigation or education for staff after the above incidents. He said he thought after the police were involved, they would do the investigation. He said he was aware of Resident #20's and , but felt it was controlled with medication. On review of previously cited deficiencies for last survey, the Administrator could not show documentation interventions or education was done on elopement or misappropriation of resident property or and neglect. 2. On at 12:00 p.m., in an interview, Medication Technician (Med Tech) Staff I said she was aware the Med Tech Staff T was not giving the 6:00 a.m. medications. She said Med Tech Staff T would show up for work drunk. She said she knew he was not giving the medications because they come in the pill pouches and when she opened the drawer there, they were. He also had a bad background screening. She said she kept telling the Administrator, but he didn't do anything about it. On at 1:30 p.m., in an interview, Med Tech Staff L said Staff T did not give the pills. Staff L would find them in the cart in the morning. The pills came from the pharmacy dated and timed for when the pills were to be given. On at 9:45 a.m., in an interview, Resident Aide ( ) Staff H said the staff on night shift, including Staff T and Staff U, were sleeping, and not doing what they were supposed to do like the	{A 030}		

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{A 030}	Continued From page 15 laundry. She said the laundry room is a mess, and the resident clothes are not being done and put away timely. She said she works 16 hour shifts and does medication as a Med Tech on Mondays and Tuesdays. She reported that Staff T is out in his car at night. She said they are smoking pot in the parking lot at night. Staff H said there is no supervision on the night shift. They are not changing residents or giving the medications. She said she had to call the cops after Staff T came into the facility drunk. She said that the Administrator is aware because she called him the night Staff T was drunk in the building. She said the Administrator told her to put Staff T on the phone, Staff T said "F**k the Administrator." He was drunk and he belittles the residents. She had to call the police on him that night and have him removed from the facility. Staff H said the Administrator is aware of all of this and keeps him on. Review of the employee records for Staff T revealed a hire date of . Staff T was not listed on the employee roster and his background screening showed he was not eligible for employment. Staff T has been working steadily in the facility and last worked on before survey. Record review revealed Staff U was hired as a resident aide. Review of the Agency's clearing house employee roster revealed Staff U was added on the clearing house roster on with a background screening that was "in process" (not eligible for employment) up to and including . Staff U has been working steadily in the facility and last worked on before survey. On at 3:15 p.m., in an interview, the	{A 030}		

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{A 030}	Continued From page 16 Administrator said he thought there was a probationary period allowed where new employees could work before being added to the clearinghouse, and when he gets busy, he forgets to add the employees and they were added late. 3. On . . . at 9:34 a.m., in a tour of the facility the hallway floor was noted to be visibly dirty and track marks noted from wheelchair tires and power chairs. There were visible spills of a dark substance on the floors in the hallway and in resident rooms that were visible from the hallway. Tour of the laundry room showed piles of laundry in various baskets in the laundry room and piled in the hallway. A resident was seen digging through the piles of laundry as if looking for something. The door to the laundry room was propped open with a bleach bottle on the floor in front of the washer. (photographic evidence obtained) On at 10:10 a.m., in an interview, Resident #21, he said his room is rarely cleaned and it has several maintenance issues that have not been address for a while. He said the maintenance man said that he would fix them, but he quit today because he said there is just too much to do and no help. Resident #21 said he does not have a door on his bathroom and his room is a semiprivate room. He said the toilet seat which is a raised seat needs to be secured so it is safe (photographic evidence obtained). Resident #21 said he did have money taken from him and he believed it happened when he was in the shower and his cloths were on the bed with his lock box key in them. When he got out of the shower, he discovered the $400 was gone. He said he called the sheriff, but nothing ever came of it. He said he is very concerned about this and would like to find a different facility to live in.	{A 030}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 030}	Continued From page 17	{A 030}		

Resident #21 said he does not feel the Administrator really investigates the issues. Resident #21 also said the laundry issue is bad and it is hard to get the laundry done and in a timely manner.

On at 12:45 p.m., in an interview, Housekeeper/ /Med Tech Staff B said sometimes the day shift staff does not show up and even though I am supposed to be doing housekeeping, I have to "take the floor" and be a resident aid or a med tech. She said herself and Staff H end up having to do meals, do medications (meds), tend to the residents. She said this happens times a week.
About 3 weeks ago we all gave the Administrator our keys and told him we were leaving. There were no consequences for the staff. We kept telling him what was wrong, but he does nothing. We knew he would not do anything. We are exhausted, we're tired. We keep telling him things, he does nothing about it.
Housekeeper Staff B said I will not clean Resident #6's room. When I was a med tech, he decided he wanted to do his own meds. One day I hear this yelling, I go and find out what it is. It was Resident #6; he hit me with a metal shoehorn. He continuously harassed me. I told the Administrator he needed to hire someone outside of here to clean his room. I filled out an incident report and called the cops. This happened about 1 year, maybe 2 years ago. Nobody wants to clean his room. He's harassed everyone who goes in his room. However, the Administrator wants to get his room clean, I don't care. Staff B said she also does the laundry. She said the overnight med tech/ is supposed to do the laundry. There are staff that are all the residents have. I came in as a med tech and have worked on housekeeping. These residents

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	AL11942866	A. BUILDING: _____ B. WING _____	R 04/27/2021

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{A 030}	Continued From page 18 are like our family. There are a few of us who have been here a while. We do our best. Staff B said she is not able to clean the hallways and common areas. She said she also had to shop for the residents and go out and buy supplies for housekeeping. Housekeeper/ /Med Tech Staff B said there is no schedule for housekeeping. She said until the Administrator starts getting good help and does not just let people run all over the place it will not get better. 4. On and on entrance to the facility there was no observed screening process for staff or visitors. No front office staff members directed surveyors to fill out a screening questionnaire or took temperatures. Staff B and Staff K were in the front office on entrance and neither attempted screening. During the 2 day survey no third party home health or staff were observed to be being screened. On at 1:35 p.m., in an interview, the Administrator confirmed there was no documentation for screening of facility staff when entering the facility. He said he provided a thermometer for screening for temperature but did not enforce the screening for staff. He said staff don't have to encourage the residents to wear a mask when out of their rooms and around others as this is their house, and they don't have to wear a mask in their house, so the residents don't have to wear mask in the facility. He said, he gives the staff masks, and he does ask them to wear them. Class II .	{A 030}		

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{A 081}	Continued From page 19	{A 081}		
{A 081}	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52(1) (1)Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the	{A 081}		

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{A 081}	Continued From page 20	{A 081}		

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

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{A 081}	Continued From page 21 following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident [illegible], neglect, and [illegible]. The facility must use its [illegible] prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure employees completed the required 2-hour pre-service orientation prior to interacting with residents for 5 (Staff M, O, P, R	{A 081}		

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{A 081}	Continued From page 22 and T) of 9 employee files reviewed. This is an uncorrected deficiency. The findings included: On at 1:00 p.m., a review of Staff M's employee file revealed a hire date of as a resident aide. Staff M's file failed to contain documentation of having completed a pre-service orientation prior to interacting with residents. On at 1:05 p.m., a review of Staff O's employee file revealed a hire date of as a resident aide. Staff O's file failed to contain documentation of having completed a pre-service orientation prior to interacting with residents. On at 1:10 p.m., a review of Staff P's employee file revealed a hire date of as a resident aide. Staff P's file failed to contain documentation of having completed a pre-service orientation prior to interacting with residents. On at 1:15 p.m., a review of Staff R's employee file revealed a hire date as a resident aide. Staff R's file failed to contain documentation of having completed a pre-service orientation prior to interacting with residents. On at 1:20 p.m., a review of Staff T's employee file revealed a hire date of as a resident aide. Staff T's file failed to contain documentation of having completed a pre-service orientation prior to interacting with residents. On /2121 at 3:15 p.m., in an interview, the Administrator acknowledged the pre-service orientations were not done prior to working with residents.	{A 081}		

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{A 081}	Continued From page 23 Class III	{A 081}		
{A 082}	59A-36.011(4) FAC Training - / . (4) . . . . . / . . . . .

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{A 082}	Continued From page 24 Class III	{A 082}		
{A 090}	59A-36.011(11) FAC Training - (11) . . . . . TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding . . . . . . (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding . . . within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure employees completed at least one hour of training in the facility's policies and procedures regarding . . . . . ( ) within 30 days of hire and maintain documentation of completion for 1 (Staff U) of 9 employee files reviewed. This is an uncorrected deficiency. The findings included: On . . , a review of Staff U's employee file revealed a hire date of as a resident aide. Staff U's file contained no documentation of having completed a in-service.	{A 090}		

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{A 090}	Continued From page 25 On [redacted] at 3:15 p.m., in an interview, the Administrator acknowledged the training was not done within 30 days of hire. Class III	{A 090}		
{A 152}	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable [redacted] to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, [redacted] or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside	{A 152}		

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{A 152}	Continued From page 26 commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . . . . . . This Statute or Rule is not met as evidenced by: Based on observation, and staff and resident interview, the facility failed to provide a safe, clean living environment for 40 of 40 residents residing in the facility. This is an uncorrected deficiency. The findings included: On at 9:34 a.m., during a tour of the facility, the hallway floor was observed to be visibly dirty and showed track marks from wheelchair tires and power chairs. There were visible spills of dark substance on the floors in the hallway. An observation of revealed the resident did not have a door on his bathroom and his raised plastic toilet seat was not secured tightly to the commode. An observation of revealed the floor tile near the bathroom was lifted slightly and a brown substance was on the floor in the bathroom. A tour of the laundry room showed piles of laundry in various, different baskets in the laundry room and piled in the hallway. A resident was seen digging through the piles of laundry as if looking for something. The door to the laundry room was propped open with a bleach bottle on the floor in front of the washer. (photographic evidence attached) On at 10:10 a.m., in an interview,	{A 152}		

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{A 152}	Continued From page 27 Resident #21 said his room is rarely cleaned and it has several maintenance issues that have not been address for a while. He said the maintenance man said that he would fix them, but he quit today because he said there is just too much to do and no help. Resident #21 said he does not have a door on his bathroom and his room is a semiprivate room. He said the toilet seat which is a raised seat needs to be secured so it is safe (photographic evidence attached). Resident #21 also said the laundry issue is bad and it is hard to get the laundry done and in a timely manner. On at 10:45 a.m., in an interview, Resident #6 said the housekeeper continued to refuse to clean his room. He said they are only supposed to clean his room when he is present as he has had money go missing in the past. He said his room is supposed to be cleaned on Tuesdays and it was Wednesday, and no one had cleaned it. He said he believed it was because the housekeeping supervisor does not like him. On at 12:45 p.m., in an interview, Housekeeper/Med Tech Staff B, said sometimes the day shift staff does not show up and even though I am supposed to be doing housekeeping I have to take the floor and be a resident aid or a med tech. She said herself and Staff H end up having to do meals, do medications (meds), tend to the residents. She said this happens times a week. About 3 weeks ago we all gave the Administrator our keys and told him we were leaving. We kept telling him what was wrong, but he does nothing. We knew he would not do anything. We are exhausted; we're tired. We keep telling him things, he does nothing about it. Housekeeper Staff B said I will not clean	{A 152}		

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{A 152}	Continued From page 28 Resident #6's room. When I was a med tech, he decided he wanted to do his own meds. One day I hear this yelling, I go and find out what it is. It was Resident #6, he hit me with a metal shoehorn. He continuously harassed me. I told the Administrator he needed to hire someone outside of here to clean his room. I filled out an incident report and called the cops. This happened about 1 year, maybe 2 years ago. Nobody wants to clean his room. He's harassed everyone who goes in his room. However, the Administrator wants to get his room clean, I don't care. Staff B said she also does the laundry. She said the overnight med tech/ is supposed to do the laundry. There are staff that are all the residents have. I came in as a med tech and have worked on housekeeping. These residents are like our family. There are a few of us who have been here a while. We do our best. Staff B said she is not able to clean the hallways and common areas. She said she also had to shop for the residents and go out and buy supplies for housekeeping. Housekeeper/Med Tech Staff B said there is no schedule for housekeeping. She said until the Administrator starts getting good help and does not just let people run all over the place it will not get better. On at 11:00 a.m., in an interview, the Administrator said housekeeping is supposed to be provided one time a week and as needed. The Administrator admitted they needed another housekeeper, but it had been hard to find help. Class III .	{A 152}		

Agency for Health Care Administration

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{A 165}	Continued From page 29	{A 165}		
{A 165}	429.23(&) FS; 59A-36.016 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident ' s condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1	{A 165}		

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{A 165}	Continued From page 30	{A 165}		

business day after the occurrence of an adverse incident, through the agency ' s online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility ' s investigation of the incident.
(4) Licensed facilities shall provide within 15 days, through the agency ' s online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility ' s investigation into the adverse incident.

(6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415.
(7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply.
(8) If the agency, through its receipt of the adverse incident reports prescribed in this part or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11942866	A. BUILDING: _____ B. WING _____	R 04/27/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 165}	Continued From page 31 through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. 59A-36.016 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1), above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on observation, record review, and staff and resident interview, the facility failed to ensure residents live in a safe, decent living environment free from . . . . . and neglect for 3 (Resident #7, #20 and #21) of 3 residents reviewed for adverse incidents. This is an uncorrected deficiency. The findings included:	{A 165}		

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{A 165}	Continued From page 32 On review of the facility's Adverse Incident Reports since the last survey the following was discovered: 1. Incident date . . . . . - an event reported to law enforcement for investigation. Resident #7 reported $17 dollars missing from her wallet. Police were called and the incident was reported to AHCA, but no investigation or analysis of the incident was done by the Administrator or his staff. No Education was done for current staff on . . neglect and , . . . 2. Incident date . . . . . - an event reported to law enforcement for investigation. Resident #21 called the sheriff's office and reported $400 money missing. Police came after the resident called them and the incident was reported to AHCA, but no investigation or analysis of the incident was done by the Administrator or his staff. No education was done for staff on . . . . . , neglect, and , . The Administrator singed off as complete on . . . . . . 3. Incident date . . . . . - an event reported to law enforcement for investigation. Resident #20 who was diagnosed with , & . . . . . went to the corner store about 3:00 p.m. on . . . . . . She was observed to be acting strange and the sheriff was called by store personnel. The sheriff brought Resident #20 to the facility. Staff were unaware that she was missing until the sheriff brought her . . . . On . . . . at 1:23 p.m., in an interview, the Administrator said he was not aware he had to do any investigation or education for staff after the above incidents. He said he thought after the police were involved, they would do the investigation. He said he was aware of Resident	{A 165}		

Agency for Health Care Administration

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{A 165}	Continued From page 33 #20's [redacted] and [redacted] but felt it was controlled with medication. On review of previously cited deficiencies for the last survey, the Administrator could show no documentation that interventions or education were done on elopement or misappropriation of resident property or [redacted] and neglect. Class II .	{A 165}		