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
	AL11969155	A. BUILDING: _____ B. WING _____	04/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACHOY ASSISTED LIVING INC	3601 W 11 AVE HIALEAH, FL 33012

(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
CZ813 SS=D	59A-35.090(3)(c), FAC Results of Screening & Notification In File 59A-35.090 Background Screening. (3) Results of Screening and Notification. (c) The eligibility results of employee screening and the signed Attestation referenced in subsection 59A-35.090(2), F.A.C., must be in the employee's personnel file, maintained by the provider. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation of an updated eligible level II background screening record for one out of fourteen sampled staff (Staff M). Findings included: A review of Staff M's personnel record showed Staff was hired on and had a level II background screening dated on file, which showed expiration date . On at 03:25 PM, the administrator stated she did not know if the background screening for Staff M was expired. She then stated maybe they had another background screening for him in the office. Unclassified	CZ813		

AHCA Form 3020-0001

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

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A 000	Initial Comments AMENDED A complaint investigation (complaint #2020017723) and a COVID-19 Monitoring were conducted at Achoy Assisted Living, Inc from to . Deficiencies were identified at the time of the survey.	A 000		
A 025 SS=H	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 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 025		

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A 025	Continued From page 1 (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 interview, the facility failed to provide adequate supervision as appropriate for each resident to ensure awareness of the general health, safety, physical and emotional well-being for five out of five sampled residents (Resident #1, #2, #3, #4 and #5). Five residents sustained between and , which resulted injures such , and . Resident #1 had a redness and to her right cheek, Resident #2 sustained a on the mid-forehead, Resident #3 complained of low , , Resident #4 sustained a pubic	A 025		

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A 025	Continued From page 2 and Resident #5 sustained a right . Findings include: 1) Adverse incident report review revealed Resident #1 was found on the floor on at approximately 09:15 AM. Staff C noticed Resident #1 on the floor and helped the resident to get to her bed. Resident #1 had redness and to her right cheek. At around 09:30 AM, the administrator/owner contacted the primary care provider, who recommended to transfer the resident to the hospital. The administrator then spoke to Resident #1's daughter who refused to send her mother to the hospital. A review of Resident #1's health assessment done on revealed the resident was diagnosed with , S/P (Status Post) Right , replacement due to right , ( ), and ( ). The physician indicated the resident needed assistance with all the activities of daily living including ambulation, bathing, , eating, self-care (grooming), toileting, and transferring. Resident #1 also needed assistance with self-administration of medications. The physician document the resident was under precaution. Adverse incident report review revealed Resident #3 get up and lost balance and on the floor in a sitting position on at 9:00 AM. The facility staff called 911, resident's daughter and primary physician. The fire rescue did not transfer the resident to the hospital. The resident was transferred to the hospital at 10:52 AM because	A 025		

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A 025	Continued From page 3 she complained of low . . . , . . On . . . . . at 12:36 PM, Staff B stated "Staff C called me, and we assisted Resident #1 to stand up from the floor. We checked her and she was fine. We contacted the administrator and she contacted resident's daughter and she refused to send her to the hospital." She said she found Resident #2 on the floor. She sat on the floor with Resident #2 and called rescue. She followed rescue instructions until they arrived. Resident #2 suffered a small . . . . . in her . . . . On . . . . . at 12:50 PM, Staff C stated she was assisting a resident walking to her bed when she observed Resident #1 on the floor. She assisted Resident #1 to get on the bed, then she called the owner. Staff C stated she checked on Resident #1 before she left the facility, and the resident was fine. She said she was taking care of Resident #2 when Resident #2 . . . She stated, "Staff B called 911 and the resident was transferred to the hospital. Resident #5 was sitting in the common area. I came with juice for the residents when she stands up and around 2:00 PM. She called rescue and the resident was transferred to the hospital." When asked why the residents kept on falling on the floor, Staff C stated, "We have two staff in the front house taking care of 13 residents all the time!" 2) Adverse incident report review revealed Resident #2 slid down the bed, trying to get up and . on the floor on at 7:03 AM. Resident #2 hit her . . . on the floor and injured her mid-forehead. The resident was transferred to the hospital at 07:35 AM with a . . . . . on the mid-forehead. A review of Resident #2's health assessment	A 025		

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A 025	Continued From page 4	A 025		

done on showed the resident was diagnosed with ( ), ( ), of native . The physician indicated the resident needed assistance with all the activities of daily living. The physician document the resident was under precaution. Progress notes document the resident went to the hospital for a and returned to the facility the same date.

3)
On at 01:10 PM, Staff D stated that Resident# 3 slid and when she was assisting her with her bath. She was all the time with her. Rescue came and checked the resident, and she was fine. Resident #4 was found on the floor around 6:30 AM. She called rescue and the resident was transfer to the hospital.

Interviewed on at 2:00 PM, Staff G stated Resident #4 had bed rails and she tried to get out from the bed and . She was checking the residents during the changes of the shift when Resident #4 was on the floor.

A review of Resident #3's health assessment completed showed the resident was to and Sulfa and had medical history and diagnoses of 's , ( ), with history , history of s/p partial around 2011, . The resident needed assistance with ambulation, bathing, , eating,

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A 025	Continued From page 5	A 025		

self-care (grooming), toileting, and transferring. The physician document the resident was under precaution. Progress notes document the resident went to the hospital for a and returned to the facility the same date.

4)
Adverse incident report review revealed Resident #4 was found on the floor in her room on at 07:46 AM. The staff tried to assist Resident #4 to get up and sit on a chair. Resident #4 had a skin to tear. Resident #4 was complaining of lower and was transferred to the hospital at 08:56 AM. Resident #4 was diagnosed with a "Pubic ".

A review of Resident #4's health assessment completed on showed the resident was diagnosed of 's bone on . The resident needed assistance with ambulation, bathing, , eating, self-care (grooming), toileting, and transferring. The physician document the resident was under precaution. Progress notes document the resident the resident was transferred to the hospital for an evaluation and treatment after a on . The resident was admitted at the hospital for a and on . The resident returned to the facility on .

5)
Adverse incident report reviews revealed Resident #5 lost balance and on the floor while trying to get up on at 02:27 PM. Resident #5 was complaining of right and was transferred to the hospital per the

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A 025	Continued From page 6 primary care physician (PCP) recommendation. Hospital discharged record showed Resident #5 was diagnosed with a "Right [redacted]". A review of Resident #5's health assessment completed on [redacted] showed the diagnosed with [redacted], Type II with [redacted], Long Term use of [redacted], ([redacted]), [redacted], Permanent [redacted]. The resident needed assistance with ambulation, bathing, [redacted], eating, self-care (grooming), toileting, and transferring. The physician document the resident was under [redacted] precaution. Progress notes document the resident was transferred to the hospital for a [redacted] and complaining for [redacted] in her right [redacted] on [redacted]. Class II	A 025		
A 030 SS=G	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	A 030		

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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 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

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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 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,

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A 030	Continued From page 9 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 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 [illegible] for health care services, the provision of or arrangement of transportation to health care	A 030		

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, 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 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

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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 Florida.

429.27 Property and personal affairs of residents.-
(1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs.
(b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or

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A 030	Continued From page 12 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 interview, the facility failed to honor the rights of the residents to receive adequate and appropriate health care for one out of six (Resident #1) sampled residents. Resident #1 after suffering a and did not receive any medical attention for over 6 hours. Resident #1 was found unresponsive, and the staff failed to perform , , ( ) on her. In addition, four other residents (Residents #2, #3, #4, and #5) in the facility within 5 months period. Three of the four residents (Resident #2, #4, and #5) suffered injuries during their . Findings included: 1- A review of facility records showed that Resident #1 was found to have at approximately 9:00 am on , was observed to have , and received no medical care. The resident was found unresponsive in a recliner at approximately 3:25 pm that afternoon. The resident, who did not have a on file, did not receive ( ). The record further stated that emergency medical services arrived at approximately 3:31 pm, and the resident was pronounced at 3:41 pm.	A 030		

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	AL11969155	A. BUILDING: _____ B. WING _____	04/19/2021

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A 030	Continued From page 13	A 030		

On . . . . . at 12:36 PM, Staff B, a direct caregiver, stated regarding the incident of Resident #1's . . on the morning of . . . . . , that she worked in Building 1 from 6:30 AM to 3:00 PM and assisted the residents with their bath, medications, and took care of all the residents' needs. Staff B then stated, "Staff C called me, and we assisted her (Resident #1) to stand up from the floor. We checked her and she was fine. We contacted the administrator and she contacted resident's daughter and she refused to send her to the hospital."

On at 12:50 PM, Staff C, a direct caregiver, stated she worked in Building 1 from 6:30 AM to 3:00 PM and assisted the residents with their bath, medications, and took care of the residents. Staff C also stated she was assisting a resident walking to her bed when she observed Resident #1 on the floor. She stated that she assisted Resident #1 to get on the bed, then she called the owner. Staff C stated she checked on Resident #1 before she left the facility, and the resident was fine.

On at 11:25 AM, Staff N, a direct caregiver, stated regarding the resident having been found unresponsive on , that she worked in Building 1 from 2:30 PM to 11:00 PM. She stated Resident #1 was sitting in a recliner in the living room area. She stated when she checked on Resident #1, she noticed Resident #1 was pale and had problem with breathing. She stated they called 911, and Staff E gave to Resident #1.

On . . . . . at 01:20 PM, Staff E, a direct caregiver who worked in Building 1 on from 2:30 PM to 9:00 PM stated Resident #1 was sitting in the common area in a recliner. She

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A 030	Continued From page 14 stated she tried to wake up Resident #1. She stated Resident #1 did not respond, but Resident #1 was breathing. Staff E stated she checked Resident #1's , and Resident #1 was fine. She stated Staff N called 911, but she was the one who spoke with the operator. Staff E claimed she put Resident #1 on the floor with the help from a third-party nurse. She stated she gave and breathing to Resident #1, but Resident #1 never woke up. A review of the ambulance run report from the local fire rescue revealed Fire Rescue Personnel found the resident on the floor on on , unresponsive, to the touch, and , The run report also noted that no was performed on Resident #1. Review of the facility's ( ) policy & procedures revealed 'the facility will administer , ( ) to residents who do not have a .' A review of Resident #1's record showed Resident #1 had no ( ) on file. A review of an adverse incident report filed showed Resident #1 was found on the floor on at approximately 09:15 AM. Staff C, a direct caregiver, noticed Resident #1 on the floor and helped the resident to get to her bed. The report noted Staff C noticed that Resident #1 had redness and to her right cheek. At around 09:30 AM, the administrator/owner contacted the primary care provider, who recommended to transfer Resident #1 to hospital. The administrator then spoke to Resident #1's daughter who refused to send her mother, Resident #1, to the hospital. At 03:25 PM, Staff N	A 030		

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A 030	Continued From page 15 noticed that Resident #1 was unresponsive and notified the Administrator. The Administrator ordered Staff N to call 911. At 15:31, local fire rescue arrived at the facility. At 03:41 PM, Resident #1 was pronounced by the local fire rescue personnel. No documentation showed Resident #1 received any type of medical care or attention after the . A review of photographic evidence taken on after the showed Resident #1's skin around the orbitals appeared . A review of Resident #1's health assessment completed on revealed Resident #1 was an female and was admitted to the facility on . Resident #1 had medical history and diagnoses of 's , S/P (Status Post) Right , replacement due to right , , , , ( ), and , ( ). Resident #1 was under precaution. Resident #1 needed assistance with all the activities of daily living including ambulation, bathing, , eating, self-care (grooming), toileting, and transferring. Resident #1 also needed assistance with self-administration of medications. 2- Interviewed on at 12:36 PM, Staff B stated she found Resident #2 on the floor. She stated she sat on the floor with Resident #2 and called rescue. She stated she followed rescue instructions until they arrived. She said Resident #2 suffered a small in her . Interview conducted with Staff C on at 12:50 PM, Staff C stated she was taking care of Resident #2 when Resident #2 . She stated,	A 030		

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A 030	Continued From page 16 "Staff B called 911 and the resident was transferred to the hospital." Staff C stated, "Resident #5 was sitting in the common area. I came with juice for the residents when she stands up and . . around 2:00 PM. I called rescue and she was transferred to the hospital. When asked why the residents kept on falling on the floor, Staff C stated, "We have two staff in the front house taking care of 13 residents all the time!" On at 01:10 PM, Staff D stated "Resident# 3 slid and . . when I was assisting her with her bath. I was all the time with her. Rescue came and checked the resident, and she was fine. Resident #4 was found on the floor around 6:30 AM. I called rescue. The resident was transfer to the hospital." Interview conducted with Staff G on at 2:00 PM, stated Resident #4 had bed rails and she tried to get out from the bed and . When asked how she knew, Staff G stated they were checking the residents during the changes of the shift, and Resident #4 was on the floor. Adverse incident report review revealed Resident #2 slid down the bed, trying to get up and on the floor on . . . . . at 7:03 AM. Resident #2 hit her on the floor and injured her mid-forehead. The resident was transferred to the hospital at 07:35 AM and received a on the mid-forehead. Record review of Resident #2 revealed the resident was admitted to the facility on . . . . The health assessment done on showed the resident was diagnosed with	A 030		

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A 030	Continued From page 17 ( ), ( ), of native . The physician indicated the resident needed assistance with all the activities of daily living. The physician document the resident was under precaution. Progress notes document the resident went to the hospital for a and returned to the facility the same date. Adverse incident report review revealed Resident #3 get up and lost balance and on the floor in a sitting position on at 9:00 AM. The facility staff called 911, resident's daughter and primary physician. The fire rescue did not transfer the resident to the hospital. The resident was transferred to the hospital at 10:52 AM because she complained of low . Review of Resident #3's record revealed she was admitted on . The health assessment completed showed the resident had medical history and diagnoses of 's ( ), with history , history of s/p partial around 2011, . The resident needed assistance with ambulation, bathing, , eating, self-care (grooming), toileting, and transferring. The physician document the resident was under precaution. Progress notes document the resident went to the hospital for a and returned to the facility the same date. Adverse incident report review revealed Resident #4 was found on the floor in her room on at 07:46 AM. The staff tried to assist Resident #4 to get up and sit on a chair. Resident	A 030		

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A	Continued From page 18 #4 had a skin to tear. Resident #4 was complaining of lower , and was transferred to the hospital at 08:56 AM. Resident #4 was diagnosed with a "Pubic ". Review of Resident #4's record revealed the resident was admitted on . The health assessment completed on showed the resident was diagnosed of 's bone on . The resident needed assistance with ambulation, bathing, , eating, self-care (grooming), toileting, and transferring. The physician document the resident was under precaution. Progress notes document the resident the resident was transferred to the hospital for an evaluation and treatment after a on . The resident was admitted at the hospital for a and on . The resident returned to the facility on . Adverse incident report review revealed Resident #5 lost balance and on the floor while trying to get up on at 02:27 PM. Resident #5 was complaining of right , and was transferred to the hospital per the primary care physician (PCP) recommendation. Hospital discharged record showed Resident #5 was diagnosed with a "Right ". A review of Resident #5's record revealed the resident was admitted on . The health assessment completed on showed the diagnosed with Type II with , , Long Term use of , ( ), , , Permanent .	A 030		

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A 030	Continued From page 19 The resident needed assistance with ambulation, bathing, , eating, self-care (grooming), toileting, and transferring. The physician document the resident needed precautions. Progress notes document the resident was transferred to the hospital for a and complaining for , in her right on . Class II	A 030		
A 079 SS=I	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 212 16-25 253 26-35 294 36-45 335 46-55 375 56-65 416 66-75 457 76-85 498 86-95 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal,	A 079		

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A 079	Continued From page 20 limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and , , ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least , must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or	A 079		

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A 079	Continued From page 21 grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the	A 079		

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A 079	Continued From page 22 facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively.	A 079		

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A 079	Continued From page 23 This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure sufficient staffing was available to meet residents scheduled and unscheduled needs. Five residents experienced . . from . . . . . , through , (Residents #1, #2, #3, #4, and #5). As a result of those . , 1 resident (Resident #1), and 3 residents sustained injuries such as . . . . and (Resident #2, #4, and #5). Findings included: Observation on showed a census of 3 caregivers and 19 residents, including 2 hospice residents: 12 residents in building 1 with 2 caregivers, and 7 residents in building 2 with 1 caregiver. A review of an adverse incident report filed in AHCA Incident Report System showed Resident #1 was found on the floor on at 9:15 AM. The resident had redness and . . . . to the right cheek. The caregiver notified the administrator who notified Resident #1' Primary Care Provider (PCP) and the family member (POA). The PCP recommended to send Resident #1 to the hospital. However, the family member told the administrator not to transfer Resident #1 to the hospital. At 03:00 PM, the caregiver found Resident #1 pale and had trouble breathing. Resident #1 was pronounced at 03:41 PM by Fire Rescue Personnel. Resident #1 received no medical attention. A review of photographic evidence taking after the showed Resident #1' skin around the orbitals was black.	A 079		

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A 079	Continued From page 24 A review of an adverse incident report filed in AHCA Incident Report System On at 7:03 AM Resident #2 slid down the bed, trying to get up and on the floor. Resident #2 hit her on the floor and injured her mid-forehead. Resident #2 was transferred to the hospital at 07:35 AM. A review of Resident #2's hospital discharged record showed Resident #2 received a on the mid-forehead from the injury sustained during the . A review of the adverse incident report filed on AHCA system showed on at 09:00 AM, Resident #3 lost balance and on the floor in a sitting position. The primary care provider recommended to send the resident to the hospital, but fire rescue went to the facility but did not take the resident to the hospital. At approximately 10:50 AM, Resident #3 was complaining of , and was transferred to the hospital for evaluation. According to the adverse incident file in AIRS, Resident #4 was found on the floor in her room on at 07:46 AM. The staff tried to assist Resident #4 to get up and sit on a chair. Resident #4 had a skin to tear. Resident #4 was complaining of lower , and was transferred to the hospital at 08:56 AM. A review of Resident #4's hospital discharged record showed Resident #4 was diagnosed with a "Pubic ". Review of the adverse incident report filed on AHCA system on , Resident #5 lost balance and on the floor at 02:27 PM while trying to get up. Resident #5 was complaining of	A 079		

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A 079	Continued From page 25 right and was transferred to the hospital per the PCP recommendation. A review of Resident #5's hospital discharged record showed Resident #5 was diagnosed with a "Right . Record review of Resident #1's health assessment completed on revealed Resident #1 was an female and was admitted to the facility on . Resident #1 had medical history and diagnoses of 's , S/P (Status Post) Right replacement due to right ( ), and ( ). Resident #1 was under precaution. Resident #1 needed assistance with all the activities of daily living including ambulation, bathing, eating, self-care (grooming), toileting, and transferring. Resident #1 also needed assistance with self-administration of medications. Record review of Resident #2's health assessment completed on showed Resident #2 was a female and was admitted to the facility on . Resident #2 had medical history and diagnoses of ( ), ( ), of native . The resident was under precautions and needed assistance with all the activities of daily living such as ambulation, bathing, eating, self-care (grooming), toileting, and transferring. Resident #2 also needed assistance with self-administration of medications.	A 079		

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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 079	Continued From page 26 Record review of Resident #3 health assessment completed on [redacted] showed Resident #3 was an [redacted] female and was admitted on [redacted]. Resident #3 was [redacted] to [redacted] and Sulfa and had medical history and diagnoses of [redacted], [redacted] with history [redacted], history of [redacted] s/p partial [redacted] around 2011, [redacted]. Resident #3 was on [redacted] precautions and needed assistance with all ADL's including ambulation, bathing, [redacted], eating, self-care (grooming), toileting, and transferring. The resident also needed assistance with self-administration of medications. Record review of Resident #4 health assessment completed on [redacted] showed Resident #4 was a [redacted] female and was admitted on [redacted]. Resident #4 had no known [redacted] and had medical history and diagnoses of [redacted] bone in [redacted]. Resident #4 was on [redacted] precautions and needed assistance with all ADL's including ambulation, bathing, [redacted], eating, self-care (grooming), toileting, and transferring. Resident #4 also needed assistance with self-administration of medications. Record review of Resident #5 health assessment completed on [redacted] showed Resident # 5 was an [redacted] female and was admitted to the facility on [redacted]. Resident #5 had no known [redacted] and had medical history and diagnoses of [redacted] Type II with [redacted], Long Term use of [redacted], Permanent [redacted]. Resident #5	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969155	A. BUILDING: _____ B. WING _____	04/19/2021

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A 079	Continued From page 27 was on precautions and needed assistance with all ADL's including ambulation, bathing, [illegible], eating, self-care (grooming), toileting, and transferring. Resident #5 also needed assistance with self-administration of medications. Interview conducted with Staff B on at 12:36 PM, Staff B stated she work from 6:30 AM to 3:00 PM in building 1. She stated she assisted the residents with their bath, medications, and take care of all their needs. She stated, "Staff C was taking care of Resident #1, and she found her on the floor. She called me and we assisted her to stand up from the floor." Staff B also stated she found Resident #2 on the floor. She stated she sat on the floor with Resident #2 and called rescue. She stated she followed rescue instructions until they arrived. She said Resident #2 suffered a small in her . Interview conducted with Staff C on at 12:50 PM, Staff C stated she worked in the facility from 6:30 AM to 3:00 PM in building 1. She stated she assisted the residents with their bath, medications, and took care of them. She stated she was in charge of Resident #1 the day of the incident. She stated she was assisting another resident walking to her bed when she observed Resident #1 on the floor. She also stated she was taking care of Resident #2 when Resident #2 . . She stated, "Staff B called 911 and the resident was transferred to the hospital." Staff C stated, "Resident #5 was sitting in the common area. I came with juice for the residents when she stands up and around 2:00 PM. I called rescue and she was transferred to the hospital. When asked why the residents kept on falling on the floor, Staff C stated, "We have two staff in the front house taking care of 13 residents all the	A 079		

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A 079	Continued From page 28 time!" On at 01:10 PM, Staff D stated she worked from 6:30 AM to 3:00 PM in building 2 and took care of 6 residents. She stated, "Resident# 3 slid and when I was assisting her with her bath. I was all the time with her. Rescue came and checked the resident, and she was fine. Resident #4 was found on the floor around 6:30 AM. I called rescue. The resident was transfer to the hospital." Interview conducted with Staff E on at 01:20 PM, Staff C stated that she worked from 02:30 PM to 09:00 PM in building 1. She stated that she took care of the residents, assisted them with their medications, and changed their diapers as needed. She stated they have two staff all the time, and she also assisted the residents with their snacks. Interview conducted with Staff G on at 2:00 PM, Staff G stated that she worked from 10:45 PM to 06:45 AM in Building 1. She stated that she checked the residents all the time. She conducted rounds and assisted the residents with all their needs. Staff G stated Resident #4 had bed rails and she tried to get out from the bed and . When asked how she knew, Staff G stated they were checking the residents during the changes of the shift, and Resident #4 was on the floor. Record reviews of 12 health assessments for Building 1 showed: - 1 resident was independent with ambulation. - 1 resident was independent with eating. - 1 resident was independent with self-care (grooming). - 1 resident required supervision with	A 079		

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A 079	Continued From page 29	A 079		

transferring.
- 4 residents required supervision with ambulation.
- 1 resident required supervision with bathing.
- 1 resident required supervision with .
- 3 residents required supervision with eating.
- 1 resident required supervision with self-care (grooming).
- 3 residents required supervision with toileting.
- 2 residents required supervision with transferring.
- 1 resident required supervision with toileting.
- 6 residents required assistance with ambulation.
- 8 residents required assistance with bathing.
- 10 residents required assistance with .
- 7 residents required assistance with eating.
- 9 residents required assistance with self-care (grooming).
- 8 residents required assistance with toileting.
- 8 residents required assistance with transferring.
- 12 residents had a risk of .

Record review for 7 residents in Building 2 showed:
- 1 resident required supervision with ambulation.
- 2 residents required supervision with eating.
- 1 resident required supervision with self-care (grooming).
- 1 resident required supervision with toileting.
- 2 residents required supervision with transferring.
- 4 residents required assistance with ambulation.
- 5 residents required assistance with bathing.
- 5 residents required assistance with .
- 3 residents required assistance with eating.

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A 079	Continued From page 30 - 4 residents required assistance with self-care (grooming). - 3 residents required supervision with toileting. - 3 residents required supervision with transferring. - 1 residents required total assistance with ambulation. - 1 residents required total assistance with bathing. - 1 residents required total assistance with . - 1 residents required total assistance with eating. - 1 residents required total assistance with self-care (grooming). - 2 residents required total assistance with toileting. - 1 residents required total assistance with transferring. - 4 residents had a risk of . . A review of the staffing schedule for Building 1 showed: The facility had 3 staff working from 07:00 AM to 03:00 PM and 03:00 PM to 11:00 PM. The facility had 2 staff working from 11:00 PM to 07:00 AM. A review of the staffing schedule for Building 2 showed: The facility had 1 staff working from 07:00 AM to 03:00 PM, 03:00 PM to 11:00 PM, and 11:00 PM to 07:00 AM. However, interviews with Staff C and Staff E showed the facility only had 2 staff working in Building 1 at all times. Class II	A 079		