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
	AL11967749	A. BUILDING: _____ B. WING _____	05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL CARE ASSISTED LIVING FACILITY	4301 31ST ST SOUTH SAINT PETERSBURG, FL 33712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation (complaint number: 2021006688 and 2021006201), a COVID-19 focused control visit, and a generator monitoring were conducted at Angel Care Assisted Living on and . Deficiencies were identified at the time of survey.	A 000		
A 025 SS=J	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 observation, record review and interview, the facility failed to provide appropriate supervision and oversight to meet the needs of residents, which included an awareness of residents' health, safety, and whereabouts, which placed all residents including seven (Residents #1, #2, #5, #13, #14, #15 and #16) of seven sampled at serious risk for and physical injury, elopement. exacerbation of their health conditions. Additionally, the facility failed to maintain residents' records with a written record update of any significant changes, and illness that resulted in medical attention for two Residents	A 025		

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A 025	Continued From page 2 (#1 and #17) of two sampled residents. Furthermore, the facility placed fourteen of fourteen memory care residents at risk for injury in the event of a fire emergency. Findings Included: 1. A review of the resident list, conducted on [redacted], revealed that the facility had fourteen residents residing in the memory care unit and fifty-six residents residing in the assisted living unit. During an interview with the local fire rescue personnel (FRP), conducted on [redacted] at 10:40am, FRP had photographic evidence that was taken on [redacted] that a bar was bolted in place obstructing one egress from the memory care unit. During an interview with the Administrator, conducted on [redacted] at 10:50am, the Administrator stated that the memory care doors had an issue and broke over the weekend and the maintenance personnel was working to correct the problem. At 11:00am, the Administrator stated that the facility placed a bar in place of the panel on [redacted] so that the memory care residents could not get out of memory care. During an observation of the memory care door, conducted on [redacted] at 11:00am, the maintenance was working on the electrical key code [redacted] and the memory care doors were in the unlocked position. During an interview with the maintenance personnel, conducted on [redacted] at 11:00am, the maintenance personnel stated that all the	A 025		

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A 025	Continued From page 3 components to the memory care doors and key code , were being redone and would be tied into the fire alarm unit. During an observation, conducted on . . . . . at 05:00am, the memory care entry door was unlocked and opened right up with no key code needed. During an interview with the maintenance employee, conducted on . . . . . at 07:19am, the maintenance employee stated that the memory care door broke sometime on . . . . . and "that night I bolted the latch in place and worked on the doors . . . . . and . . . . . ." The maintenance employee stated that he was still working on the doors at this time. During an observation of . 's exit, conducted on at 05:15am, revealed that the door was unlocked and had a . . . door that was also unlocked and to the left of this door was the pathway to the facility. This was not a secure area and led to the rest of the property and made an easy escape for memory care residents that were elopement risks and exit seekers. 2. During an interview with the local fire rescue personnel (FRP), conducted on . . . . . at 10:40am, the FRP stated that the facility had one staff on duty on . . . . . when they responded to the facility at approximately 04:00am to transport Resident #1 from the memory care unit to the emergency department after sustaining a . The only staff on duty, could not provide any paperwork for Resident #1. When the employee attempted to telephone the Administrator, there was no response and there was no other staff	A 025		

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A 025	Continued From page 4	A 025		

present in the building. The FRP stated that there had been more than one incident that they could not find staff after 05:00pm and the problem obtaining resident information was getting worse.

During an observation of Resident #1, conducted on [illegible] at 10:58am, Resident #1 was lying in bed on her left side. She had bright purple [illegible] to her right [illegible].

During a review of Resident #1's hospital report, conducted on , revealed that Resident #1 presented to the emergency department due to an unwitnessed and that emergency personnel could only obtain her name and "no other information related to her past medical history", insurance information, or medication list and that the resident was non-verbal. Resident #1 had " [illegible] bridge [illegible] with scant [illegible], mild deviation to the right". Resident #1 sustained a " [illegible] mildly displaced [illegible] bone [illegible] associated with soft tissue [illegible] of the [illegible]" and " [illegible] fragments displaced to the left".

A record review for Resident #1, conducted on [illegible], revealed that Resident #1 resided in the memory care unit and was admitted into the facility on [illegible]. Resident #1's health assessment form had no date of the examination and her diagnoses included [illegible]'s, [illegible], Cachexia. Resident #1 required supervision with bathing and grooming and assistance with self-administration of medications. Resident #1 required daily oversight for wellbeing and whereabouts and reminders for important tasks. Resident #1 had an incident report dated for [illegible] found to the

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A 025	Continued From page 5 resident's , , , and . There was no evidence found that Resident #1's primary care or responsible party were notified of the injuries. There was no evidence found that the facility obtained medical treatment for the resident's injury. There was no documentation of the incident in Resident #1's record. There was no evidence of an investigation of the resident's injuries. During an interview with the Administrator, conducted on at 01:39pm, the Adminsitrator stated that an incident report was to be written for any type of incident. The Administrator stated that she did not have an incident report for Resident #1's on and no, that a one-day Adverse Incident Report was not submitted to the Agency for Health Care Administration. The Administrator stated that the facility did not maintain logs about changes in condition, medical treatment, , or notifications to residents' health care providers and responsible parties in their resident records. The Administrator confirmed that there was no documenation regarding Resident #1's with and need for emergency medical care in the resident's record. During an interview with Resident #13 and Resident #14, conducted on at 11:26am, Resident #13 and #14 stated that staff take a long time to answer call lights or do not respond at all to them. A record review for Resident #13, conducted on , revealed that Resident #13 resided in the assisted living unit and was admitted into the Facility on . Resident #13's health assessment form dated and her	A 025		

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A 025	Continued From page 6 diagnoses included , unsteady gait, . Resident #13 required assistance with bathing and medications and required daily oversight for wellbeing and whereabouts and reminders for important tasks. During an interview with Resident #15, conducted on at 11:30am, Resident #15 stated that the facility was short-staffed and that she has to wait for help. A record review for Resident #15, conducted on , revealed that Resident #15 resided in the assisted living unit and was admitted into the Facility on . Resident #15's health assessment form dated and her diagnoses included , Obstruction , , and used a walker or wheelchair for ambulation. Resident #15 required precautions. Resident #15 required supervision with ambulation and assistance with bathing and medications. Resident #15 required daily oversight for wellbeing and whereabouts and reminders for important tasks. During an interview with Resident #5, conducted on at 02:30pm, Resident #5 stated that the facility was short-handed and that the staff do not answer his call light when he calls for help. Resident #5 stated that the Administrator told him that he did not need a call light. A record review for Resident #5, conducted on , revealed that Resident #5 resided in the assisted living unit and was admitted on . Resident #5's health assessment form dated and his diagnoses included , , Post Stress	A 025		

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A 025	Continued From page 7 , & . Resident #5 required precautions and required assistance with ambulation and transferring. Resident #5 required daily oversight for wellbeing and whereabouts and reminders for important tasks. A review of the Residency Agreement/Contract, conducted on , revealed that the facility agreed to provide each unit/apartment with an emergency pull cord in the bedroom and bathroom to call for assistance. During an interview with the Administrator, conducted on at 04:30pm, the Administrator verified that Resident #5's call light was properly functioning. A record review for Resident #16, conducted on , revealed that Resident #16 resided in the memory care unit and was admitted into the Facility on . Resident #16's health assessment form, dated , was documented on the form and not on the required form and her diagnoses included , Frequent , Abnormal Gait, with Behavioral Disturbances, generalized , & memory loss. Resident #16 required precautions and assistance with ambulation, bathing, , toileting, transferring, and medications. Resident #16 required daily oversight for wellbeing and whereabouts and reminders for important tasks. A review of the Facility's Risk Management Policy and Procedures (RMP&P), conducted on , revealed that RMP&P stated that monitor risk resident whereabouts and when a resident has a change in behavior or health condition that is unusual to the facility staff, the	A 025		

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A 025	Continued From page 8 staff will immediately contact the primary care provider ...and family, and send the resident to the hospital. The RMP&P stated that if a resident sustained an observed or unobserved , the staff should refrain from picking them up and if the required more than first aid, (emergency medical services) must be called immediately and that the staff must stay with the resident until help arrives. The RMP&P stated that the Administrator would notify residents' health care providers and report the incident and obtain further orders and the family member point of contact should be notified about the incident. The incident should be documented in the staff communication log and an incident report must be filled out by the staff who observed the or found the injury. During an interview with Staff A, conducted on at 05:15am, Staff A stated that it was hard to get a hold of the Administrator at night. Staff A stated that she was the only employee on duty on and attempted to notify the Administrator several times on and to inform her that she was the only employee on duty. Staff A stated that there were two other employees (Staff D and Staff E) scheduled to work that shift but neither showed up for their shift. Staff A stated that she was present in the memory care unit when Resident #1 and heard a boom and saw the resident on the floor from her . Staff A stated that she did not know what to do and the 911 operator told her what to do. A review of Staff A's cellular telephone log, conducted on , revealed that the Administrator's personal cellular telephone number was attempted at on at 11:35pm, 11:36pm, 11:37pm, 11:40pm, 11:41pm,	A 025		

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A 025	Continued From page 9 and 11:46pm and on . . . . . at 12:18am, and 01:04am and the Business Office Manager's telephone at 04:46am. During an interview with Staff B, conducted on . . . . . at 05:20am, Staff B stated that Residents #2, #3, #4, and #15 received medications during the night. During a phone interview with the Administrator, conducted on . . . . . at 05:15am, the Administrator stated that she was not able to come to the facility for two hours and that there was no one with access to residents, staff, or facility records. During an observation with Resident #5, conducted on . . . . . at 11:33am, Resident #5's bedside call light cord was pulled. The Receptionist entered the room at 11:36am with two packages in her . . . . The Receptionist stated that she had a package and set the package down. The Receptionist did not acknowledge that Resident #5's call light was on or ask him if he needed anything. The Receptionist left as swiftly as she had arrived with the other package in . . . . At 11:53am, there was no response from staff to find out the assistance that Resident #5 required. The pull cord was unreachable by Resident #5 who was lying in his bed as the cord was too short to reach him. Resident #5 ambulated in a wheelchair and the call cord would have been difficult for him to reach when sitting up in his wheelchair in the event of an emergency. Resident #5 stated that his roommate, Resident #17, had . . . . . twice in a row a couple of months ago and had not returned from the hospital yet. During an interview with the Administrator,	A 025		

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A 025	Continued From page 10 conducted on . . . . . at 11:55am, the Administrator stated that Resident #5's call light was working on . . . . . and would have maintenance look at it. During an interview with the Administrator, conducted on . . . . at11:55am the Administrator stated that Resident #17 went to the hospital because he was weak and did not have a and was now in a rehabilitation facility. The Administrator stated that he a couple of times prior to this hospitalization but came and was sent this time for . . . . but he didn't . Documentation of the prior , hospital records, documentation in the resident's record regarding the hospitalizations and changes in condition were requested. The Administrator was unable to provide the documentation requested. Class I	A 025		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is	A 054		

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A 054	Continued From page 11 offered or administered and include: 1. The name of the resident and any known [illegible] the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical [illegible], the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to immediately update Medication Observation Records (MORs) each time a medication was offered to four Residents (#1, #2, #3, and #4) of four sampled residents that required assistance with self-administration of medications. Findings Included: A MORs review for Resident #1, conducted on [illegible], revealed that medications were not documented as given to the resident for the [illegible] MORs with the prescribed medications: - [illegible] 10mg was not documented as given on [illegible], and [illegible] at 08:00am. 5, 16, 17, & 30 at 8am - [illegible] 125mg was not documented as given on [illegible], and [illegible] at 09:00am	A 054		

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A 054	Continued From page 12 - [redacted] 50mcg was not documented as given on [redacted] at 07:00am. Resident #1 required assistance with self-administration of medications. A MORs review for Resident #2, conducted on [redacted], revealed that medications were not documented as given to the residents for the [redacted] MORs with the prescribed medication [redacted] 15mg was not documented as given on [redacted] /201, [redacted] at 05:00am and [redacted] at 01:00am. Resident #2 required assistance with self-administration of medications. A MORs review for Resident #3, conducted on [redacted], revealed that medications were not documented as given to the residents for the [redacted] MORs with the prescribed medication [redacted] 15mg was not documented as given on [redacted] at 12:00pm and [redacted] at 12:00am. Resident #3 required assistance with self-administration of medications. A MORs review for Resident #4, conducted on [redacted], revealed that medications were not documented as given to the residents for the [redacted] MORs with the prescribed medication [redacted] 5mg was not documented as given on [redacted] at 06:00am and [redacted] /2021at 12:00am. Resident #4 required assistance with self-administration of medications. During an interview with the Administrator, conducted on [redacted] at 04:00pm, the	A 054		

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A 054	Continued From page 13 Administrator agreed that medications were not documented as given to Resident #1. On [redacted] at 09:30am, the Administrator agreed that Residents #2, #3, and #4 had medication that were not documented as given to the residents. The Administrator offered no reason or explanation. Class III	A 054		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of	A 055		

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A 055	Continued From page 14 physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has	A 055		

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A 055	Continued From page 15 ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the Facility failed to keep centrally stored medication in a locked cabinet or cart secured at all times (photographic evidence obtained). Findings Included: Observations, conducted on [redacted], revealed that the Facility did not keep centrally stored medications in a locked cabinet or cart and secured at all times. - At 10:54am, there was a large stack of medication packs in the Administrator's office stacked in a corner and not in a locked cabinet or cart. The Administrator left her office to tour with the local fire rescue personnel at 11:00am and did not lock her office door.	A 055		

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A 055	Continued From page 16 - At 11:35am, the Administrator's office was observed with the door wide open, and there was no staff was inside the office. The medications continued as stacked in the corner. - At 11:36am, the South medication desk had the medication storage room doors wide open. There was no staff present in or around the desk or medication room. The was a refrigerator with .. .. medications that was not locked/secured. There were food items stored with the medication. There was a cabinet opposite the refrigerator that was full of medications that was not locked/secured. Observations, conducted on .. .. , revealed that the Facility did not keep centrally stored medications in a locked cabinet or cart and secure at all times. - At 05:00am, the South medication desk medication storage room door was wide open. The refrigerator continued with .. .. medication and food items and not locked and secures. The cabinet full of medications continued to be unlocked. - At 10:20am, the Administrator's office door was wide open and there was no staff inside the office. The stack of medication continued as described on . During an interview with the Administrator, conducted on .. .. at 03:35pm, the administrator agreed that all medication must be locked and secure at all times. Class III	A 055		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders	A 056		

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A 056	Continued From page 17 (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with chapters 465 and 499, F.S., and rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new	A 056		

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A 056	Continued From page 18	A 056		

directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record.
(e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable.
(f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner.
(g) Pursuant to section 465.0276(5), F.S., and rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following:
1. Practitioner's name,
2. Resident's name,
3. Date dispensed,
4. Name and strength of the drug,
5. Directions for use; and,
6. Expiration date.
(h) Pursuant to section 465.0276(2)(c), F.S., before dispensing any sample or complimentary

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A 056	Continued From page 19 prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to provide prescribed medications as ordered from resident's Health Care Providers and failed to notify their Health Care Providers when residents did not receive their prescribed medications as ordered for four Residents (#1, #2, #3, and #4) of four sampled residents that required assistance with self-administration of meds. Findings Included: A review of Resident #1's Medication Observation Records (MORs), conducted on , revealed that Resident #1 prescribed medications 10mg, 40mg, 15mg, and 5mg were circled as not given on at 08:00pm because the resident refused the medications. There was no evidence that more that one attempt was made to get Resideht #1 to take her medications as prescribed. There was no evidence that Resident #1's health care provider and responsible party were notified that she did not take her medications as prescribed. A review of Resident #2's MORs, conducted on , revealed that Resident #2's 15mg was not signed as given on at 05:00am. A review of Resident #3's MORs, conducted on , revealed that Resident #3's 15mg was not signed as given	A 056		

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A 056	Continued From page 20 on . . . . . at 06:00am. A review of Resident #4's . , . MORs, conducted on , revealed that Resident #4's . , ... 5mg was not signed as given on at 06:00am. During an interview by the Administrator with Staff A, conducted on . . . . . at 01:25pm, Staff A told the Administrator that she worked by herself in the Facility and that the other scheduled employees did not show up for their work duties. A record review for Staff A, conducted on . . . . . , revealed that Staff A had no training as a Medication Technician and was not qualified to assist residents with their medications. During an interview with the Administrator, conducted on at 09:30am, the Administrator agreed that Residents #2, #3, and #4 did not receive their medications on because there was no qualified staff on duty to provide the medications. The Administrator was unable to provide evidence that Residents #1, #2, #3, and #4s' health care providers and responsible parties were notified that the residents did not receive their medications as ordered. At 04:00pm, the Administrator stated that her staff did not inform her that Resident #1 refused her medications. Class III	A 056		
A 077 SS=J	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued,	A 077		

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A 077	Continued From page 21 the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least [illegible]; 2. If employed on or after [illegible], have, at a minimum, a high school diploma or	A 077		

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A 077	Continued From page 22 G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to , are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a	A 077		

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A 077	Continued From page 23 separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No =Ref-09393. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the Facility failed to be under the supervision of an Administrator that was responsible for the operation and maintenance of the facility. Additionally, the facility failed to provide appropriate care to all residents, which placed residents in danger in the event of a fire	A 077		

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A 077	Continued From page 24	A 077		

emergency and at risk for elopement. Furthermore, the facility failed to provide management of staff and adequate staffing levels, which placed residents at risk from exacerbation of health conditions, delay in emergency medical treatment, and physical injury due to and missing their medications.

Findings Included:

1. During an interview with fire rescue personnel (FRP), conducted on at 10:41am, they stated they responded to a medical emergency on at approximately 04:23am regarding a resident who had and sustained a injury. Upon arrival they could not find any employees and the doors of the memory care unit were bolted with a latch that prevented anyone from entering or exiting the unit, thus obstructing one egress in the event of an emergency. Shortly after their arrival they found one staff working. The FRP stated the employee on duty did not have access to any resident records and could not provide any medical, demographical or insurance information for the resident being transported. The FRP stated the employee called the Administrator but did not get a response. The FRP also stated there have been other instances when fire rescue has responded to emergent calls from the facility after 5:00pm and they could not find staff or obtain needed paperwork to transport residents.

During an interview with the Administrator, conducted on at 11:10am, the Administrator stated that Staff A and Staff E worked on the 11pm-7am shift on when Resident #1 was sent to the hospital.

A review of the employee time cards, conducted

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A 077	Continued From page 25 on .. .. , revealed Staff A was the only employee on duty on from 01:04am through 05:21am with a census of 70 residents. During interviews with Staff, conducted on , the employees stated: - At 11:15am, Staff G stated the facility was short-staffed. - At 01:25pm, Staff A stated she worked on for the 11pm-7am shift by herself and no other staff showed up. - At 03:25pm, Staff B stated there had been one staff in the building on ... . Staff B stated that quite frequently the facility had two employees for the entire building, and this happened quite often on the 3pm-11pm and the 11pm-7am shifts. - At 04:35pm, Staff I stated the facility needed more housekeeping and care staff. During interviews with residents conducted on .. .. , the residents stated: - At 11:26am, Residents #13 and #14 stated that they had a hard time finding staff and that the staff take a long time to answer call lights or do not answer the call lights at all. - At 11:30am, Resident #15 stated that she had to wait for help when she needs it. - At 02:30pm, Resident #5 stated that the facility was short-handed, and the call lights were broken, or staff do not answer them. During an interview with Staff A conducted on . at 05:15am, Staff A stated: - It was hard to get ahold of the Administrator at night and that she had telephoned the Administrator on ... ... at 11:35pm, 11:36pm, 11:37pm, 11:40pm, 11:41pm, and 11:46pm and	A 077		

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A 077	Continued From page 26 again on ... ... at 12:18am, and 01:04am to inform that she was alone in the building. Staff A showed the Surveyor her telephone resent call log. Staff A also attempted to notify the Business Office Manager via telephone on ... ... at 04:46am regarding Resident #1's . - Staff A stated that Emergency Personnel were mad due to the memory care door being bolted shut and staff had to let them in through , which was an unlocked storage room with a door that led to the outside and was not kept locked. This allowed for easy access for exit seeking memory care residents at risk for elopements. - Staff A stated the facility did not train her regarding emergency procedures or what paperwork to send with a resident to the hospital. She did not have access to Resident #1's demographic sheet, insurance information, or medication list. - Staff A stated she did a couple of observation rounds in the assisted living unit on to make sure the residents on the unit were breathing, which left the fourteen memory care residents unattended during those rounds. - Staff A stated this was the second time the employee was left alone in the facility. The first time was in , but does not remember the exact date. Staff A stated the Administrator told her at that time to go and forth between the assisted living unit and the memory care unit. A review of the employee timecard punches, conducted on , revealed: -On ... ... Staff F was working alone in the entire building from 02:35am through 03:10am. - On ... ... Staff A was working alone in the entire building from 01:04am through 06:41am. On ... ... Staff A was working alone in the entire building from 03:14am through 03:29am.	A 077		

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A 077	Continued From page 27 On . . . . . Staff A was working alone in the entire building from 12:49am through 05:21am. On . . . . . Staff A was working alone in the entire building from 12:02am until one of the 7am-3pm employees clocked in on . . . . . . 2. During an observation conducted on at 11:00am, the maintenance personnel were working on the memory care doors. The doors remained unlocked/unsecured throughout the hours of the survey from 5:00am until 5:00pm. Upon arrival to the facility on . . . . . at 05:00am, the memory care doors opened without a key code and no staff were present to observe entry and exit of the doors. During an interview with the facility's maintenance person, conducted on . . . . . at 11:00am, they stated the magnet broke on the memory care unit door and there was a bar in place over the weekend to prevent the residents from exiting. On . . . . . at 07:19am, the maintenance person stated that he bolted the latch in place on the night of . . . . . because the memory care door key code , was not functioning, preventing the doors from remaining secure. 3. Observations, conducted on from 11:08am through 11:26am, revealed environmental hazards in the memory care unit that included: chemicals were not locked and secured in a storage room and housekeeping cart. The bathroom sinks, toilets, bathtubs and floors were dirty. There were faucets with buildup of corrosion. There were cracked shower tiles and torn shower curtains. The metal door frames were rusted. There were window style air conditioning units with no front covers and a thick	A 077		

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A 077	Continued From page 28 buildup of dust accumulation. The outside of the units had a buildup of black bio-growth and dust or dirt to the air vents. There was clutter inside rooms and on porches of the rooms of rusted half bed rails, rusted and dirty wheelchairs, rusted and dirty walkers, and a dirty mattress with bio-growth. Some of the resident bathrooms did not have toilet paper. There were walls with paint peeling off. The baseboards, walls, and doors were dirty throughout. The light switch in the dining room was filthy with an unknown brown substance smeared over it. One resident dining table was worn. The wall-to-wall windows in the dining room were filthy making the view hazy. The cabinet drawers in the dining room were missing or broken. sanitizer and soap dispensers were dusty and spotty with unknown substance and many were empty. During observation conducted on at 11:00am and 11:35am there was a pile of medications in the Administrator's office that were not locked and secured. At the south medication desk, there was a storage room with the door wide open and there was a cabinet full of oral medications and refrigerator full of medications. During observation conducted on at 10:20am there was still a pile of medications in the Administrator's office that were not locked and secured. At the south medication desk, there was a storage room with the door wide open and there was a cabinet full of oral medications and refrigerator full of medications. During an interview with Staff B on at 05:45am, Staff B identified that Residents #2, #3, #4, and #15 had orders to receive medications during the 11pm-7am shift. On and	A 077		

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A 077	Continued From page 29 a medication technician was not available during this shift to assist the residents with their medications resulting in residents not receiving their scheduled medications. A review of Resident #2, #3, and #4's Medication Observation Records, conducted on , revealed that Resident #2 did not receive his prescribed , 15mg on at 05:00am; Resident #3 did not receive her prescribed , 15mg on at 06:00am; and Resident #4 did not receive her prescribed , 5mg on at 06:00am. 4. During interviews with the Administrator on , the Administrator stated that: - At 01:39pm, that with any type of incident we have to write an incident report and no, she did not have an incident report for Resident #1. The Administrator stated that she did not submit an Adverse Incident Report to the Agency for Health Care Administration to report the resident's bone. The Administrator stated that there was no documentation in Resident #1's record regarding the found on or the sustained on or any other changes in condition or hospitalizations. The Administrator was unable to provide evidence that Resident #1's health care provider or responsible parties were notified of either incident. - At 03:35pm, the Administrator agreed that: o Medications were to be locked at all times. o The memory care needed cleaning and throughout to include sinks, toilets, bathtubs, floors, baseboards, light switches, doorknobs, windows, baseboards, walls, and	A 077		

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A 077	Continued From page 30 doors. o Chemicals left unattended can be a hazard to memory care residents and should be kept locked. o The air conditioning units needed to be cleaned or replaced and that the dirty filters and bio-growth. o Rusted wheelchairs, walkers, and bed rails can be a risk for . . or injury if not properly stored. o The buildup of corrosive faucets, rusted door frames/wheelchairs/walkers/bedrails, cracked tiles, torn shower curtains, peeling paint, broken cabinets, and worn dining table were unsightly and not homelike. o All resident bathrooms should have toilet paper and soap and that all . . sanitizing stations should have sanitizer. - At 04:30pm, the Administrator confirmed that Resident #5's call light was functioning properly. During interviews with the Administrator on , the Administrator stated that: - At 05:15am, that she was unable to come into Facility for two hours and there was no staff with access to Facility, resident, or employee records. - At 11:00am, she agreed that employees were missing required trainings. - At 09:30am, she agreed that Residents #2, #3, and #4 did not receive their morning medications on . . . . . because there was no Medication Technician working to provide the scheduled medications. Class I	A 077		

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A 079	Continued From page 31	A 079		
A 079 SS=J	59A-36.010(3) FAC Staffing Standards - Levels	A 079		

(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
[illegible]	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, 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

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A 079	Continued From page 32 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 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	A 079		

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A 079	Continued From page 33	A 079		

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 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

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A 079	Continued From page 34 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. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide adequate staffing to meet the scheduled and unscheduled needs of residents which placed seventy (70) residents at risk of harm and/or injury, for exacerbation of their health care conditions, , , missing their medications, delay in needed medical treatment, and elopement due to the lack of staffing. Additionally, the facility failed to provide at least one staff member that had access to facility and resident records.	A 079		

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A 079	Continued From page 35 Furthermore, the facility failed to provide a staff member in the building at all times that had completed training in First Aid and , , ( ). Findings Included: 1. During an interview with the local fire rescue personnel (FRP), conducted on at 10:40am, the FRP stated that fire rescue entered the building on because 911 had been called to transport Resident #1 to the emergency room. The FRP stated that rescue personnel found that Staff A was the only staff present in the building. Staff A was unable to provide Resident #1's demographic data that included her responsible party's contact information, primary care provider's information, insurance and medical information such as diagnoses, , and medication list. The FRP had to transport the resident to the emergency room without this information. The FRP stated there had been more than one incident after 5pm where fire rescue could not find any staff when they were called to the facility and this was getting worse. A review of the resident daily checklist, conducted on , revealed there were fourteen (14) residents that resided in the memory care unit and fifty-six (56) residents that resided in the assisted living unit for a total of seventy (70) residents residing in the facility. During record reviews for memory care residents, conducted on , revealed that all fourteen residents' age range was 56 to , and had diagnoses such as or , 's , , , , abnormal gait and used assistive devices such as a walker or	A 079		

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A 079	Continued From page 36 wheelchair, risk, and more. All fourteen of these residents required supervision and or assistance with some or all of their activities of daily living and with self-administration of medications. These residents required a secured unit due to their risk for elopement. During record reviews for assisted living residents, conducted on , revealed that the residents had diagnoses that included but were not limited to , , , with behavioral disturbances, , , , , , generalized , abnormal or unsteady gait and used assistive devices such as walker or wheelchair, risk and history, , and more. The assisted living residents required supervision and or assistance with some or all of their activities of daily living and with self-administration of medications. During an observation of Resident #1, conducted on at 10:58am, Resident #1 was lying in bed on her left side. She had bright purple to her right , . During a review of Resident #1's hospital report, conducted on , revealed that Resident #1 presented to the emergency department due to an unwitnessed and that emergency personnel could only obtain her name and "no other information related to her past medical history", insurance information, or medication list and that the resident was non-verbal. Resident #1 had " bridge with scant , mild deviation to the right". Resident #1 sustained a " mildly displaced bone associated with soft tissue of the " and " fragments displaced to the	A 079		

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A 079	Continued From page 37 left". A record review for Resident #1, conducted on , revealed that Resident #1 resided in the memory care unit and was admitted into the facility on . Resident #1's health assessment form had no date of the examination and her diagnoses included 's, , , Cachexia. Resident #1 required supervision with bathing and grooming and assistance with medications. Resident #1 required daily oversight for wellbeing and whereabouts and reminders for important tasks. There was no address or telephone number of the Examiner. Resident #1 had an incident report dated for found to the resident's , , , and . There was no evidence found that Resident #1's primary care or responsible party were notified of the injuries. There was no evidence found that the Facility obtained medical treatment for the resident's possible injury. There was no documentation of the incident in Resident #1's record. There was no evidence of an investigation of the resident's injuries. During a telephone interview with Staff A, conducted on at 01:25pm, Staff A stated to the Administrator that it was "just me, by myself" that was working on Saturday night (referring to the 11pm-7am shift starting on and ending on at 7am). Staff A stated that Staff D and Staff E never showed up. During an interview with Staff A, conducted on at 05:15am, Staff A stated: - That there were two other staff scheduled to work the 11pm-7am shift on and two	A 079		

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A 079	Continued From page 38	A 079		

employees did not show up for their duties.
- That she attempted to notify the Administrator via telephone several times of this and got no response from her.
- That she performed a couple of rounds on the residents residing in the assisted living unit to make sure everyone was breathing and that there was no staff present in the memory care unit when she did those rounds.
- That she was scared and never experienced a resident [redacted] like that and was never trained in the facility's emergency procedures for the proper paperwork to send to the hospital with residents.
- That she could not find the paperwork that emergency personnel were asking for when Resident #1 was sent to the hospital on [redacted].
- That she was never given a password to retrieve resident documents from the computer.
- That she attempted to notify the Business Office Manager via telephone at 04:46am on [redacted] and there was no response.
- That this was the second time in a month she had been left alone to care for the entire resident population in the facility. The first time, she was able to notify the Administrator that she was the only staff present and was told to go [redacted] and forth between the assisted living and the memory care.

A review of Staff A's cellular telephone log, conducted on [redacted] at 05:15am, revealed that Staff A attempted to call the Administrator's personal cellular telephone number on at 11:35pm, 11:36pm, 11:37pm, 11:40pm, 11:41pm, and 11:46pm and on [redacted] at 12:18am and 01:04am.

A record review for Staff A, (date of hire [redacted]) conducted on [redacted], revealed that

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A 079	Continued From page 39 Staff A had no evidence of trainings in her employee record for First Aid and , the Facility's emergency procedures, activities of daily living and behavioral needs, resident rights and recognizing , neglect, and , , or incident reporting. Staff A did not have evidence that she had obtained a 6-hours Medication Technician Training. A record review for the Administrator conducted on , revealed that the Administrator did not have evidence that she had completed training in . A record review for Staff I and Staff J conducted on , revealed that Staff I and J did not have evidence that they had completed training in First Aid and . 2. During an interview with Staff G, conducted on at 11:15am, Staff G stated that sometimes the facility was short staffed. During an interview with Residents #13 and #14, conducted on at 11:26am, Residents #13 and #14 stated that they sometimes cannot find staff, and the staff take a long time to answer the call light or do not answer the call light at all. During an interview with Resident #15, conducted on at 11:30am, Resident #15 stated that there was not enough staff and residents had to wait for help. During an interview with Resident #5, conducted on at 02:30pm, Resident #5 stated that the facility was short-handed and lacked staff to assist with his needs. He stated that the staff do not answer his call light when he calls for help. Resident #5 stated that the Administrator told him	A 079		

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	AL11967749	A. BUILDING: _____ B. WING _____	05/11/2021

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A 079	Continued From page 40 that he did not need a call light. A record review for Resident #5, conducted on , revealed that Resident #5 resided in the assisted living unit and was admitted on . Resident #5's health assessment form dated and his diagnoses included , , , , . Resident #5 required precautions and required assistance with ambulation and transferring. Resident #5 required daily oversight for wellbeing and whereabouts and reminders for important tasks. During an interview with Staff B, conducted on at 03:25pm, Staff B stated that there was one staff working on the 11pm-7am shift on . Staff B stated that this happens quite often. Staff B stated about three Sundays ago that she was left to work alone in the facility and had no other choice. Staff B stated that the facility was mainly shorthanded on the 3pm-11pm and the 11pm-7am shifts. During an interview with Staff C, conducted on at 04:00pm, Staff C stated that the facility was sometimes short-staffed and was left to work alone in the facility once. During an interview with Staff I, conducted on at 04:35pm, Staff I stated that the facility needed more staff and had worked when there was one staff in the memory care unit and one staff in the assisted living unit. A review of the staffing schedule, conducted on , revealed that Staff A and Staff E were scheduled to work the third shift (11pm-7am) on into . There were no other employees scheduled for that shift. Staff A was	A 079		

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A 079	Continued From page 41 scheduled as a Resident Aid and Medication Technician on , , and . A review of employee timesheets conducted on revealed the following: - On Staff C clocked out from her job duties at 12:49am and that Staff A was the only staff on duty from 12:49am through 5:21am - On Staff A clocked out from 02:35am through 03:10am, which left Staff F working alone for the entire building. - On , Staff C clocked out at 01:04am, which left Staff A working alone for the entire building until 06:41am. - On Staff D clocked off duty from 03:03am through 03:29am and Staff F clocked off duty from 03:14am through 03:44am. This left Staff A working alone for the entire building from 03:14am through 03:29am. - On Staff A worked by herself from 12:49am through 05:21am. - On , Staff A worked alone for the entire building which started at 12:02am. 3. During an interview with Staff C, conducted on at 05:45am, Staff C stated that Residents #2, #3, #4, and #15 had scheduled medications during the night. A record review for Resident #2, conducted on , revealed Resident #2 required assistance with self-administration of medications according to her undated health assessment form. Resident #2 had the prescribed medication , 15mg scheduled on at 06:00am. Resident #2 did not receive this medication dose.	A 079		

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A 079	Continued From page 42 A record review for Resident #3, conducted on , revealed Resident #3 required assistance with self-administration of medications according to her undated health assessment form. Resident #3 had the prescribed medication , 15mg scheduled on at 06:00am. Resident #3 did not receive this medication dose. A record review for Resident #4, conducted on , revealed Resident #4 required assistance with self-administration of medications according to her health assessment form dated . Resident #4 had the prescribed medication , 5mg scheduled on at 06:00am. Resident #4 did not receive this medication dose. During an interview with the Administrator, conducted on at 09:30am, the Administrator stated that Residents #2, #3, and #4 did not receive their prescribed medication doses because there was not a qualified staff to assist with medication. Class I	A 079		
A 081 SS=D	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	A 081		

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A 081	Continued From page 43	A 081		

employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record.

(7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course.

59A-36.011
(2) STAFF PRESERVICE ORIENTATION.
(a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1).
(b) New staff must complete the preservice orientation prior to interacting with residents.
(c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record.
(d) In addition to topics that may be chosen by the facility administrator, the preservice 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

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A 081	Continued From page 44 facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when 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:	A 081		

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A 081	Continued From page 45 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 provide direct care staff with the required in-service trainings, which included trainings for emergency procedures, incident reporting, activities of daily living, and resident rights and recognizing and reporting , neglect, and within thirty days of hire for two employees (Staff A and Staff J) of three sampled employees. Findings Included: During an interview with Staff A, conducted on at 05:15am, Staff A stated that she had not been trained in the Facility policy and procedures for emergency procedures. Staff A	A 081		

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A 081	Continued From page 46 stated that "they never showed me anything for emergencies or what paperwork to send" with a resident to the emergency room. An employee record review for Staff A, conducted on , revealed that Staff A's record did not contain evidence that the employee had completed the required trainings for emergency procedures, incident reporting, activities of daily living, and resident rights and recognizing and reporting , neglect, and within thirty days of hire. Staff A was hired on . An employee record review for Staff J, conducted on , revealed that Staff J's record did not contain evidence that the employee had completed the required trainings for emergency procedures, incident reporting, activities of daily living, and resident rights and recognizing and reporting , neglect, and within thirty days of hire. Staff J was hired on . During an interview with the Administrator, conducted on at 11:00am, the Administrator was unable to provide evidence that Staff A and J completed trainings for emergency procedures, incident reporting, activities of daily living, and resident rights and recognizing and reporting , neglect, and within thirty days of hire. Class III	A 081		
A 086 SS=D	59A-36.011(10) FAC Training - ADRD (10) AND RELATED ("ADRD") TRAINING REQUIREMENTS. Facilities which advertise that	A 086		

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A 086	Continued From page 47	A 086		

they provide special care for persons with ADRD, or who maintain secured areas as described in Chapter 4, Section 464.4.6 of the Florida Building Code, as adopted in rule 61G20-1.001, F.A.C., Florida Building Code Adopted, must ensure that facility staff receive the following training.
(a) Facility staff who interact on a daily basis with residents with ADRD but do not provide direct care to such residents and staff who provide direct care to residents with ADRD, shall obtain 4 hours of initial training within 3 months of employment. Completion of the core training program between , ..., ... and .. , , ... shall satisfy this requirement. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. Initial training, entitled " ..... and Related ..... Level I Training," must address the following subject areas:
1. Understanding .... 's ..... and related ;
2. Characteristics of ..... ;
3. Communicating with residents with 's ..... ;
4. Family issues;
5. Resident environment; and,
6. Ethical issues.
(b) Staff who have successfully completed both the initial one hour and continuing three hours of ADRD training pursuant to sections 400.1755, 429.917 and 400.6045(1), F.S., shall be considered to have met the initial assisted living facility and Related ..... Level I Training.
(c) Facility staff who provide direct care to residents with ADRD must obtain an additional 4 hours of training, entitled "
and Related ..... Level II Training," within 9

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A 086	Continued From page 48 months of employment. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. and Related Level II Training must address the following subject areas as they apply to these : 1. Behavior management, 2. Assistance with ADLs, 3. Activities for residents, 4. Stress management for the care giver; and, 5. Medical information. (d) A detailed description of the subject areas that must be included in an ADRD curriculum which meets the requirements of paragraphs (a) and (b) of this subsection, can be found in the document "Training Guidelines for the Special Care of Persons with 's and Related ," dated , incorporated by reference, available from the Department of Elder Affairs, 4040 Esplanade Way, Tallahassee, Florida 32399-7000. (e) Direct care staff shall participate in 4 hours of continuing education annually as required under section 429.178, F.S. Continuing education received under this paragraph may be used to meet 3 of the 12 hours of continuing education required by section 429.52, F.S., and subsection (1) of this rule, or 3 of the 6 hours of continuing education for extended congregate care required by subsection (7) of this rule. (f) Facility staff who have only incidental contact with residents with ADRD must receive general written information provided by the facility on interacting with such residents, as required under section 429.178, F.S., within three (3) months of employment. "Incidental contact" means all staff who neither provide direct care nor are in regular contact with such residents.	A 086		

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A 086	Continued From page 49 (g) Persons who seek to provide ADRD training in accordance with this subsection must provide the department or its designee with documentation that they hold a Bachelor's degree from an accredited college or university or hold a license as a registered nurse, and: 1. Have 1 year teaching experience as an educator of caregivers for persons with . . . . . or related . . . . . , or 2. Three years of practical experience in a program providing care to persons with . . . . or related . . . . , or 3. Completed a specialized training program in the subject matter of this program and have a minimum of two years of practical experience in a program providing care to persons with . . . . . or related . . . . . . (h) With reference to requirements in paragraph (g), a Master's degree from an accredited college or university in a subject related to the content of this training program can substitute for the teaching experience. Years of teaching experience related to the subject matter of this training program may substitute on a year-by-year basis for the required Bachelor's degree referenced in paragraph (g). This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide the required training regarding . . . . . and related . . . . . (ADRD) for two employees (Administrator and Staff J) of three sampled employees that interacted daily with residents with 's and . . . . . . Findings Included: A record review for the Administrator, conducted on , revealed that the Administrator did	A 086		

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A 086	Continued From page 50 not have a four-hour update training for ADRD. The Administrator completed the Level-II ADRD training on //2018. There was no other evidence after this date for ADRD training updates. A record review for Staff J, conducted on , revealed that there was no evidence in Staff J's employee record that the staff had completed a four-hour required training for ADRD Level-1 training within three months of employment. Staff J was hired on . During an interview with the Administrator, conducted on at 11:00am, the Administrator stated that there was no four-hour update training for ADRD in her record and that Staff J had not completed the ADRD Level-I training. Class III	A 086		
A 152 SS=D	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	A 152		

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A 152	Continued From page 51 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 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 [redacted]. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to honor resident rights by failing to provide a safe, clean, decent, and homelike environment free from hazards in the memory care unit. Furthermore, the Facility failed to maintain all existing mechanical and electrical systems in good working order (photographic evidence obtained). Findings Included: During an interview with fire rescue personnel (FRP), conducted on [redacted] at 10:40am, the FRP stated that when the responded to a medical emergency on [redacted] at approximately	A 152		

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A 152	Continued From page 52 04:23am, they found that the memory care doors were bolted with a latch that prevented anyone from entering or exiting the memory care unit thus obstructing one egress in the event of a fire emergency. The FRP provided photographic evidence that was taken at that time. During an observation of the memory care door, conducted on .. .. at 11:00am, the maintenance personnel was working on the memory care doors. The doors remained unlocked/unsecured throughout the day. The doors remained unlocked/unsecured by end of this survey day at 05:00pm. On at 05:00am, there was no staff present observing the memory care doors and the doors opened without a key code access and remained broken. During an interview with the Facility's maintenance person, conducted on at 11:00am, the maintenance person stated that there was a bar in place over the weekend so that the memory care residents did not get out of the unit because the magnet broke. On at 07:19am, the maintenance person stated that he bolted the latch in place on the night of because the memory care door key code , , was not functioning, and the doors were not secure and did not lock. Observations, conducted on . . . . from 11:08am through 11:26am, revealed environment hazards in the memory care unit that included: - There was a storage room that had the door propped open with unsecured chemicals in this room. There was a house keeping cart parked in the hallway by . The housekeeping cart had a storage area full of chemicals and the double doors to the cart were ajar/opened.	A 152		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967749	A. BUILDING: _____ B. WING _____	05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL CARE ASSISTED LIVING FACILITY	4301 31ST ST SOUTH SAINT PETERSBURG, FL 33712

(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 152	Continued From page 53 - had rusted metal door frame to the bathroom. The floor around the toilet and bathtub was visibly dirty. The ceramic shower tile was cracked. The window style air conditioner had no front panel on it and the filter appeared old. There was a rusted half side rail in the corner on the floor. - had a window style air conditioner that had no front panel on it and the filter was caked with dust accumulation. There was a mattress on the resident's porch that had black bio-growth on it. The shower curtain was torn, and the bathtub was visibly dirty. The toilet was visibly dirty and the floor surrounding the toilet was dirty with an unknown brownish substance. There was no toilet paper in the resident's bathroom room at any time throughout survey. - had a window style air conditioning unit with black bio-growth covering the outside air vents. There were rusted wheelchairs, walkers, and half side rails stored on this porch. Clutter of walkers and chairs can be seen from this porch surrounding a shed. - had a bathtub faucet with thick corrosion covering it and rust stains in the bathtub. - had paint peeling from the wall above the window style air condition unit. The shower holder was broken, and it was hanging downward. - had a visibly dirty shower, shower mat, and sink. - The memory care dining room had one table that was worn. The lights switch had a brown substance smeared all over it. The walls, baseboards, doors, floors, counters were visibly dirty. There were missing and broken drawers in the cabinets. The wall to wall windows were visibly dirty and hazy.	A 152		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967749	A. BUILDING: _____ B. WING _____	05/11/2021

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A 152	Continued From page 54 During a review of the fire inspection report dated , conducted on , the Fire Inspector issued seven citations regarding the Facility's memory care access-controlled egress doors, exit sign illumination, key lock to memory care patio gate, means of egress free of obstructions, means of egress marking to patio gate, outlet above fire panel, and egress door without approved hardware. The re-inspection was scheduled for . During an interview with the Administrator, conducted on at 03:35pm, the Administrator agreed that the memory care needed cleaning and throughout to sinks, toilets, bathtubs, floors, baseboards, light switches, doorknobs, windows, baseboards, walls, doors. The Administrator agreed that chemicals left unattended can be a hazard to memory care residents and should be kept locked. The Administrator agreed that the air conditioning units needed to be cleaned or replaced and that the dirty filters and bio-growth can cause exacerbation of , or and other , issues. The Administrator agreed that the rusted wheelchairs, walkers, and bed rails can be a risk for or injury if not properly stored. The Administrator agreed that the buildup of corrosive faucets, rusted door frames/wheelchairs/walkers/bedrails, cracked tiles, torn shower curtains, peeling paint, broken cabinets, and worn dining table were unsightly and not homelike. The Administrator agreed that all resident bathrooms should have toilet paper and soap and that all sanitizing stations should have sanitizer. Class III	A 152		