

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVING SOUTHERN STYLE OF BREVARD LLC

**1721 ROCKLEDGE DRIVE
ROCKLEDGE, FL 32955**

(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 re-licensure survey with Limited Mental Health and generator and control monitoring were conducted at Living Southern Style of Brevard on Deficiencies were found at the time of the visit.	A 000		
A 025 SS=D	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) Monitoring of the quantity and quality of	A 025		

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/10/2021
NAME OF PROVIDER OR SUPPLIER LIVING SOUTHERN STYLE OF BREVARD LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1721 ROCKLEDGE DRIVE ROCKLEDGE, FL 32955		
(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 025	Continued From page 1 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 maintain written documentation and updates for significant changes which required medical attention and notification of the resident's healthcare provider and family for 1 of 2 sampled residents (#6). Findings: Review of the record for resident #6 revealed an admission date of The most recent health assessment form, dated, was completed following a hospital admission. The form documented diagnoses including	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
NAME OF PROVIDER OR SUPPLIER LIVING SOUTHERN STYLE OF BREVARD LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1721 ROCKLEDGE DRIVE ROCKLEDGE, FL 32955		
(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 025	Continued From page 2 ... and hard of hearing. She was noted to be at risk for ... and used a walker for ambulation. She required assistance with self-administered medications. There was no documentation found in the record describing changes in the resident's condition that led to a hospital admission, or if the resident's healthcare provider or responsible party was notified. On ... at 12:30PM, the administrator confirmed resident #6 was admitted to the hospital in ... She confirmed she did not have any observation notes regarding the circumstances leading to the hospital stay or if the provider or family was notified. Class III	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 offered or administered and include: 1. The name of the resident and any known ... the resident may have;	A 054		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
NAME OF PROVIDER OR SUPPLIER LIVING SOUTHERN STYLE OF BREVARD LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1721 ROCKLEDGE DRIVE ROCKLEDGE, FL 32955		
(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 054	Continued From page 3 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 _____, 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 observation, electronic medication observation record (eMOR) review and interview, the facility failed to ensure the eMOR was accurate and complete for 1 of 1 sampled resident (#5). Findings: Review of the eMOR for _____ revealed multiple holes in the documentation. None of the 16 medications ordered to be given at 8:00AM daily were documented as given on _____, 4, 5, 8, 9, and 10. _____ 25mg-100mg, ordered to be given at 2:00PM, was not signed as given on _____, 4 or 8. _____ 100mg was ordered to be given at 2:00PM daily, but was not signed as given on _____, 4, 8 or 9. _____ 25mg-100mg, ordered to be given at 8:00PM, was not signed as given on _____, 7, or 8. The following medications were ordered to be given at 8:00PM, were not signed as given on _____, 7, 8 or 9: _____ 50mg-200mg, _____ 20mg, _____ 100mg, _____ 15mg, and _____ 40mg.	A 054		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
NAME OF PROVIDER OR SUPPLIER LIVING SOUTHERN STYLE OF BREVARD LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1721 ROCKLEDGE DRIVE ROCKLEDGE, FL 32955		
(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 054	Continued From page 4 D2, 1.25mg was written on the eMOR to given "once a day, Saturday, every week." It was marked as given on . . . and no other dates after There was no clarification of the order found. It was not shown as being given daily or weekly. (photographic evidence obtained) On at 2:25PM, staff A confirmed the eMOR documentation was not complete. On at 2:25PM, the administrator stated there was a portable tablet the staff were to use at the cart while assisting with medications so they would not have to remember to go . . . to the office computer afterwards. She confirmed the eMOR was incomplete. Class III	A 054		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care	A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVING SOUTHERN STYLE OF BREVARD LLC

**1721 ROCKLEDGE DRIVE
ROCKLEDGE, FL 32955**

(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 078	Continued From page 5 provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff	A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
NAME OF PROVIDER OR SUPPLIER LIVING SOUTHERN STYLE OF BREVARD LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1721 ROCKLEDGE DRIVE ROCKLEDGE, FL 32955		
(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 078	Continued From page 6 position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff _____ by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to ensure each employee presented documentation of freedom from communicable _____ upon hire and annual documentation of freedom from _____ () for 3 of 4 sampled staff (A, C, D). Findings: 1. Review of the personnel record for staff A, caregiver hired on _____, revealed the most recent documentation of freedom from _____ was dated _____. 2. Review of the personnel record for staff C, caregiver hired _____, revealed the most recent documentation of freedom from _____ was dated _____. 3. Review of the personnel record for staff D, caregiver hired in _____, did not reveal any documentation of freedom from communicable _____ including _____. On _____ at 1:30PM, the administrator confirmed the findings. Class III	A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVING SOUTHERN STYLE OF BREVARD LLC

**1721 ROCKLEDGE DRIVE
ROCKLEDGE, FL 32955**

(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 SS=D	Continued From page 7 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: <table border="0"> <tr> <td>Number of Residents, Day Care Participants, and Respite Care Residents</td> <td>Staff Hours/Week</td> </tr> <tr> <td>0-5</td> <td>168</td> </tr> <tr> <td>6-15</td> <td>212</td> </tr> <tr> <td>16-25</td> <td>253</td> </tr> <tr> <td>26-35</td> <td>294</td> </tr> <tr> <td>36-45</td> <td>335</td> </tr> <tr> <td>46-55</td> <td>375</td> </tr> <tr> <td>56-65</td> <td>416</td> </tr> <tr> <td>66-75</td> <td>457</td> </tr> <tr> <td>76-85</td> <td>498</td> </tr> <tr> <td>86-95</td> <td>539</td> </tr> </table> 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	Number of Residents, Day Care Participants, and Respite Care Residents	Staff Hours/Week	0-5	168	6-15	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	A 079 A 079		
Number of Residents, Day Care Participants, and Respite Care Residents	Staff Hours/Week																									
0-5	168																									
6-15	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																									

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVING SOUTHERN STYLE OF BREVARD LLC

**1721 ROCKLEDGE DRIVE
ROCKLEDGE, FL 32955**

(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 8 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		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVING SOUTHERN STYLE OF BREVARD LLC

**1721 ROCKLEDGE DRIVE
ROCKLEDGE, FL 32955**

(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 9 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	A 079		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVING SOUTHERN STYLE OF BREVARD LLC

**1721 ROCKLEDGE DRIVE
ROCKLEDGE, FL 32955**

(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 10 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 record review and interview, the facility failed to 1) maintain a current and accurate written work schedule that reflected its 24-hour staffing pattern for a given time period, and 2) did not meet the minimum staffing hours required for a census of 6 residents. Findings On the facility had a census of 6 residents.	A 079		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVING SOUTHERN STYLE OF BREVARD LLC

**1721 ROCKLEDGE DRIVE
ROCKLEDGE, FL 32955**

(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 11 Request to review the current staff schedule revealed the most recent written schedule was for On at 9:10AM, caregiver A stated the staffing hours were: staff A 8:00AM-2:00PM staff B 10:00AM-5:00PM staff C 5:00PM-11:00AM staff D (administrator) worked overnight from 11:00PM-8:00AM. The schedule described by staff A equals 196 hours per week. The minimum requirement for a census of 6 residents is 212 hours per week. On at 1:10PM, the administrator confirmed she did not have a current printed schedule since and confirmed the staffing hours were less than 212 for the previous week. Class III	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 employee and the administrator of the facility must sign a statement that the employee	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVING SOUTHERN STYLE OF BREVARD LLC

**1721 ROCKLEDGE DRIVE
ROCKLEDGE, FL 32955**

(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 081	Continued From page 12 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 facility staff: (a) Staff who provide direct care to residents,	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVING SOUTHERN STYLE OF BREVARD LLC

**1721 ROCKLEDGE DRIVE
ROCKLEDGE, FL 32955**

(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 081	Continued From page 13 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 bloodborne pathogens, 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 abuse, neglect, and self-harm. 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: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVING SOUTHERN STYLE OF BREVARD LLC

**1721 ROCKLEDGE DRIVE
ROCKLEDGE, FL 32955**

(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 081	Continued From page 14 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 staff schedule review, personnel record review and interview, the facility failed to ensure 3 of 4 sampled staff had received the required training within 30 days of hire (B, C & D). Findings: 1. Review of the personnel record for staff B, administrator since 2012, did not reveal documentation for a 1-hour training in control or a 3-hour training in activities of daily living (ADL) and behavioral needs. No documentation was found to show staff B was a licensed nurse, certified nursing assistant or home health aide which would exempt her from the training.	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVING SOUTHERN STYLE OF BREVARD LLC

**1721 ROCKLEDGE DRIVE
ROCKLEDGE, FL 32955**

(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 081	Continued From page 15 2. Review of the personnel record for staff C, caregiver hired , did not reveal a certificate for the required 2-hour pre-service orientation. No documentation for a 1-hour training in control or a 3-hour training in activities of daily living (ADL) and behavioral needs. No documentation was found to show staff C was a licensed nurse, certified nursing assistant or home health aide which would exempt her from the training. The record was not found to contain any documentation for training specific to the facility's policies and procedures for emergency including chain of command and evacuation, incident reporting, the facility's policies for recognizing and reporting , neglect and , the facility's elopement policy, and safe food handling. 3. Review of the personnel record for staff D, caregiver hired in , did not reveal a certificate for the required 2-hour pre-service orientation. No documentation for a 1-hour training in control or a 3-hour training in activities of daily living (ADL) and behavioral needs. No documentation was found to show staff D was a licensed nurse, certified nursing assistant or home health aide which would exempt her from the training. The record was not found to contain any documentation for training specific to the facility's policies and procedures for emergency including chain of command and evacuation, incident reporting, the facility's policies for recognizing and reporting , neglect and , the facility's elopement policy, and safe food handling. On at 1:45PM, the administrator confirmed the findings.	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVING SOUTHERN STYLE OF BREVARD LLC

**1721 ROCKLEDGE DRIVE
ROCKLEDGE, FL 32955**

(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 081	Continued From page 16 Class III	A 081		
A 082 SS=D	59A-36.011(4) FAC Training - / (4) Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on and , including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule. This Statute or Rule is not met as evidenced by: Based on personnel record review and interview for 2 of 4 sampled staff (C & D) the facility failed to ensure all staff had completed a one-time education course on () and (Acquired -Deficiency), including the topics prescribed in the Section 381.0035, F.S. Findings: Staff C, caregiver, was hired on . Staff D, caregiver, was hired in . Review of the personnel records for staff C & D did not reveal any documentation for training / . On at 1:35PM, the administrator confirmed the findings.	A 082		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
NAME OF PROVIDER OR SUPPLIER LIVING SOUTHERN STYLE OF BREVARD LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1721 ROCKLEDGE DRIVE ROCKLEDGE, FL 32955		
(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)	
A 082	Continued From page 17 Class III	A 082		
A 083 SS=D	59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND . (). 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 that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American . . . Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on staff schedule review, personnel record review and interview, the facility failed to ensure 1 of 4 sampled staff who was schedule to work alone with the residents had current, valid training in First Aid (D). Findings: Request to review the current staff schedule revealed the most recent written schedule was for	A 083		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
NAME OF PROVIDER OR SUPPLIER LIVING SOUTHERN STYLE OF BREVARD LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1721 ROCKLEDGE DRIVE ROCKLEDGE, FL 32955		
(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 083	Continued From page 18 On at 9:10AM, caregiver A stated she worked from 8:00AM-2:00PM, staff B worked 10:00AM-5:00PM, staff C worked 5:00PM-11:00AM, and the administrator worked overnight from 11:00PM-8:00AM. Review of the personnel record for staff D, caregiver hired in , did not reveal any documentation she had received training in First Aid. On at 1:35PM, the administrator confirmed the findings and said she thought the training also included First Aid. The administrator stated she would work in place of staff D until she completed the training. Class III	A 083		
A 090 SS=D	59A-36.011(11) FAC Training - (11) TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C.	A 090		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/10/2021
NAME OF PROVIDER OR SUPPLIER LIVING SOUTHERN STYLE OF BREVARD LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1721 ROCKLEDGE DRIVE ROCKLEDGE, FL 32955		
(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 090	Continued From page 19 This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to ensure that all direct care staff were trained in the facility's policies and procedures related to () for 2 of 4 sampled staff (C, D). Findings: Staff C, caregiver, was hired on Staff D, caregiver, was hired in Review of the personnel records for staff C & D did not reveal any documentation for training on the facility's policies and procedures. On at 1:35PM, the administrator confirmed the findings. Class III	A 090			
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			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVING SOUTHERN STYLE OF BREVARD LLC

**1721 ROCKLEDGE DRIVE
ROCKLEDGE, FL 32955**

(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 20 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 height to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, 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 soiled. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure furniture located in a dining room was maintained in safe condition. Findings: Observation on _____ at 9:20AM, while seated at the dining table in the front room closest to the bedroom for residents #1 & #6, the surveyor found it was very wobbly. The round tabletop moved significantly on the base when touched. At 12:10PM on _____, resident #6, who is at risk for _____ and uses a walker to ambulate, was observed being seated at the wobbly table.	A 152		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVING SOUTHERN STYLE OF BREVARD LLC

**1721 ROCKLEDGE DRIVE
ROCKLEDGE, FL 32955**

(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 21 On at 1:30PM, the administrator confirmed the finding. Class III	A 152		
A 161 SS=D	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in section	A 161		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVING SOUTHERN STYLE OF BREVARD LLC

**1721 ROCKLEDGE DRIVE
ROCKLEDGE, FL 32955**

(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 161	Continued From page 22 429.174, F.S., and rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity that contracts to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to ensure all staff records contained a copy of the signed and dated employment application including references for 1 of 4 sampled staff. (D) Findings: Review of the personnel record for staff D, caregiver hired in _____, _____, did not reveal an employment application. On _____ at 1:35PM, the administrator confirmed she did not have an application for staff D.	A 161		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
NAME OF PROVIDER OR SUPPLIER LIVING SOUTHERN STYLE OF BREVARD LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1721 ROCKLEDGE DRIVE ROCKLEDGE, FL 32955		
(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 161	Continued From page 23 Class III	A 161		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C. (f) A record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
NAME OF PROVIDER OR SUPPLIER LIVING SOUTHERN STYLE OF BREVARD LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1721 ROCKLEDGE DRIVE ROCKLEDGE, FL 32955		
(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 162	Continued From page 24 receiving assistance with the activities of daily living must have their ☒ recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S. (l) If the resident is an _____ recipient, a copy of the Department of Children and Families form Alternate Care Certification for _____, _____ (_____), CF-ES 1006, _____, which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004 . The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/10/2021
NAME OF PROVIDER OR SUPPLIER LIVING SOUTHERN STYLE OF BREVARD LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1721 ROCKLEDGE DRIVE ROCKLEDGE, FL 32955		
(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 162	Continued From page 25 and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVING SOUTHERN STYLE OF BREVARD LLC

**1721 ROCKLEDGE DRIVE
ROCKLEDGE, FL 32955**

(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 162	Continued From page 26 facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure the record for 2 of 2 sampled residents (#1 & #6) contained a signed written informed consent for unlicensed staff to assist residents with self-administered medications. Findings: On at 8:30AM, staff A confirmed the facility utilizes unlicensed staff to assist with self-administration of medications. 1. Review of the record for resident #1 revealed an admission date of . The most recent health assessment form, dated , indicated that she required assistance with self-administered medications. No signed informed consent for unlicensed staff to assist with medications was found in the record. 2. Review of the record for resident #6 revealed an admission date of . The most recent health assessment form, dated , indicated that she required assistance with self-administered medications. A blank, unsigned informed consent for unlicensed staff to assist with medications was found in the record. (photographic evidence obtained) On at 12:25PM, the administrator	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
NAME OF PROVIDER OR SUPPLIER LIVING SOUTHERN STYLE OF BREVARD LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1721 ROCKLEDGE DRIVE ROCKLEDGE, FL 32955		
(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 162	Continued From page 27 confirmed the findings. Class III	A 162		
A 167 SS=D	59A-36.018 FAC; 429.24 FS Resident Contracts 59A-36.018 Resident Contracts. (1) Pursuant to section 429.24, F.S., the facility must offer a contract for execution by the resident or the resident's legal representative before or at the time of admission. The contract must contain the following provisions: (a) A list of the specific services, supplies and accommodations to be provided by the facility to the resident, including limited nursing and extended congregate care services that the resident elects to receive; (b) The daily, weekly, or monthly rate; (c) A list of any additional services and charges to be provided that are not included in the daily, weekly, or monthly rates, or a reference to a separate fee schedule that must be attached to the contract; (d) A provision stating that at least 30 days written notice will be given before any rate increase; (e) Any rights, duties, or _____ of residents, other than those specified in section 429.28, F.S.; (f) The purpose of any advance payments or deposit payments, and the refund policy for such advance or deposit payments; (g) A refund policy that must conform to section 429.24(3), F.S.; (h) A written bed hold policy and provisions for terminating a bed hold agreement if a facility agrees in writing to reserve a bed for a resident who is admitted to a nursing home, health care facility, or _____ facility. The resident or responsible party must notify the facility in writing of any change in status that would prevent the	A 167		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/10/2021
NAME OF PROVIDER OR SUPPLIER LIVING SOUTHERN STYLE OF BREVARD LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1721 ROCKLEDGE DRIVE ROCKLEDGE, FL 32955		
(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 167	Continued From page 28 resident from returning to the facility. Until such written notice is received, the agreed upon daily, weekly, or monthly rate may be charged by the facility unless the resident's medical condition prevents the resident from giving written notification, such as when a resident is comatose, and the resident does not have a responsible party to act on the resident's behalf; (i) A provision stating whether the facility is affiliated with any religious organization and, if so, which organization and its relationship to the facility; (j) A provision that, upon determination by the administrator or health care provider that the resident needs services beyond those that the facility is licensed to provide, the resident or the resident's representative, or agency acting on the resident's behalf, must be notified in writing that the resident must make arrangements for transfer to a care setting that is able to provide services needed by the resident. In the event the resident has no one to represent him or her, the facility must refer the resident to the social service agency for placement. If there is disagreement regarding the appropriateness of placement, provisions outlined in section 429.26(8), F.S., will take effect; (k) A provision that residents must be assessed upon admission pursuant to subsection 59A-36.006(2), F.A.C., and every 3 years thereafter, or after a significant change, pursuant to subsection (4), of that rule; (l) The facility's policies and procedures for self-administration, assistance with self-administration, and administration of medications, if applicable, pursuant to rule 59A-36.008, F.A.C. This also includes provisions regarding over-the-counter (OTC) products pursuant to subsection (8) of that rule; and,	A 167			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/10/2021
NAME OF PROVIDER OR SUPPLIER LIVING SOUTHERN STYLE OF BREVARD LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1721 ROCKLEDGE DRIVE ROCKLEDGE, FL 32955		
(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 167	Continued From page 29 (m) The facility's policies and procedures related to a properly executed DH Form 1896, (2) The resident, or the resident's representative, must be provided with a copy of the executed contract. (3) The facility may not levy an additional charge for any supplies, services, or accommodations that the facility has agreed by contract to provide as part of the standard daily, weekly, or monthly rate. The resident or resident's representative must be furnished in advance with an itemized written statement setting forth additional charges for any services, supplies, or accommodations available to residents not covered under the contract. An addendum must be added to the resident contract to reflect the additional services, supplies, or accommodations not provided under the original agreement. Such addendum must be dated and signed by the facility and the resident or resident's legal representative and a copy given to the resident or resident's representative. 429.24 FS (1) The presence of each resident in a facility shall be covered by a contract, executed at the time of admission or prior thereto, between the licensee and the resident or his or her designee or legal representative. Each party to the contract shall be provided with a duplicate original thereof, and the licensee shall keep on file in the facility all such contracts. The licensee may not destroy or otherwise dispose of any such contract until 5 years after its expiration. (2) Each contract must contain express provisions specifically setting forth the services and accommodations to be provided by the facility; the rates or charges; provision for at least	A 167			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/10/2021
NAME OF PROVIDER OR SUPPLIER LIVING SOUTHERN STYLE OF BREVARD LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1721 ROCKLEDGE DRIVE ROCKLEDGE, FL 32955		
(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 167	Continued From page 30 30 days' written notice of a rate increase; the rights, duties, and _____ of the residents, other than those specified in s. 429.28; and other matters that the parties deem appropriate. A new service or accommodation added to, or implemented in, a resident's contract for which the resident was not previously charged does not require a 30-day written notice of a rate increase. Whenever money is deposited or advanced by a resident in a contract as security for performance of the contract agreement or as advance rent for other than the next immediate rental period: (a) Such funds shall be deposited in a banking institution in this state that is located, if possible, in the same community in which the facility is located; shall be kept separate from the funds and property of the facility; may not be represented as part of the assets of the facility on financial statements; and shall be used, or otherwise expended, only for the account of the resident. (b) The licensee shall, within 30 days of receipt of advance rent or a security deposit, notify the resident or residents in writing of the manner in which the licensee is holding the advance rent or security deposit and state the name and address of the depository where the moneys are being held. The licensee shall notify residents of the facility's policy on advance deposits. (3)(a) The contract shall include a refund policy to be implemented at the time of a resident's transfer, discharge, or _____. (b) If a licensee agrees to reserve a bed for a resident who is admitted to a medical facility, including, but not limited to, a nursing home, health care facility, or _____ facility, the resident or his or her responsible party shall notify the licensee of any change in status that would	A 167			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/10/2021
NAME OF PROVIDER OR SUPPLIER LIVING SOUTHERN STYLE OF BREVARD LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1721 ROCKLEDGE DRIVE ROCKLEDGE, FL 32955		
(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 167	Continued From page 31 prevent the resident from returning to the facility. Until such notice is received, the agreed-upon daily rate may be charged by the licensee. (c) The purpose of any advance payment and a refund policy for such payment, including any advance payment for housing, meals, or personal services, shall be covered in the contract. (4) The contract shall state whether or not the facility is affiliated with any religious organization and, if so, which organization and its general responsibility to the facility. (5) Neither the contract nor any provision thereof relieves any licensee of any requirement or imposed upon it by this part or rules adopted under this part. (6) In lieu of the provisions of this section, facilities certified under chapter 651 shall comply with the requirements of s. 651.055. (7) Notwithstanding the provisions of this section, facilities which consist of 60 or more apartments may require refund policies and termination notices in accordance with the provisions of part II of chapter 83, provided that the lease is terminated automatically without financial penalty in the event of a resident's hospitalization or to medical reasons which necessitate services or care beyond which the facility is licensed to provide. The date of termination in such instances shall be the date the unit is fully vacated. A lease may be substituted for the contract if it meets the disclosure requirements of this section. For the purpose of this section, the term "apartment" means a room or set of rooms with a kitchen or kitchenette and lavatory located within one or	A 167			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/10/2021
NAME OF PROVIDER OR SUPPLIER LIVING SOUTHERN STYLE OF BREVARD LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1721 ROCKLEDGE DRIVE ROCKLEDGE, FL 32955		
(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 167	Continued From page 32 more buildings containing other similar or like residential units. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a residency agreement between the facility and the resident, or their designee had been executed at or prior to admission for 1 of 2 sampled residents, as required in 429.24, F.S. (#1) Findings: Review of the record for resident #1 revealed an admission date of . No residency agreement or contract was found in the record. On . . . at 12:25PM, the administrator confirmed the findings. Class III	A 167			
AL243 SS=D	429.075(1) FS; 59A-36.011(9) FAC LMH - Training 429.075 (1) To obtain a limited mental health license, a facility must hold a standard license as an assisted living facility, must not have any current uncorrected violations, and must ensure that, within 6 months after receiving a limited mental health license, the facility administrator and the staff of the facility who are in direct contact with mental health residents must complete training of no less than 6 hours related to their duties. This designation may be made at the time of initial licensure or relicensure or upon request in writing	AL243			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVING SOUTHERN STYLE OF BREVARD LLC

**1721 ROCKLEDGE DRIVE
ROCKLEDGE, FL 32955**

(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
AL243	Continued From page 33 by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with this part, part II of chapter 408, and applicable rules. This training must be provided by or approved by the Department of Children and Families. 59A-36.011 (9) LIMITED MENTAL HEALTH TRAINING. (a) Pursuant to section 429.075, F.S., the administrator, managers and staff, who have direct contact with mental health residents in a licensed limited mental health facility, must receive the following training: 1. A minimum of 6 hours of specialized training in working with individuals with mental health diagnoses. a. The training must be provided or approved by the Department of Children and Families and must be taken within 6 months of the facility's receiving a limited mental health license or within 6 months of employment in a limited mental health facility. b. Training received under this subparagraph may count once for 6 of the 12 hours of continuing education required for administrators and managers pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 2. A minimum of 3 hours of continuing education, which may be provided by the ALF administrator, online, or through distance learning, biennially thereafter in subjects dealing with one or more of the following topics: a. Mental health diagnoses; and, b. Mental health treatment such as: (i) Mental health needs, services, behaviors and appropriate interventions; (ii) Resident progress in achieving treatment goals;	AL243		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVING SOUTHERN STYLE OF BREVARD LLC

**1721 ROCKLEDGE DRIVE
ROCKLEDGE, FL 32955**

(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
AL243	Continued From page 34 (III) How to recognize changes in the resident's status or condition that may affect other services received or may require intervention; and, () Crisis services and the procedures. 3. For administrators and managers, the continuing education requirement under this subsection will satisfy 3 of the 12 hours of continuing education required biennially pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 4. Administrators, managers and direct contact staff affected by the continuing education requirement under this subsection shall have up to 6 months after the effective date of this rule to meet the training requirement. (b) Administrators, managers and staff do not have to repeat the initial training should they change employers provided they present a copy of their training certificate to the current employer for retention in the facility's personnel files. They must also ensure that copies of the continuing education training certificates, pursuant to subparagraph (a)2. of this subsection, are retained in their personnel files. This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to ensure that 2 of 4 staff (A, C) completed the initial 6 hour Limited Mental Health (LMH) training within 6 months of hire as required by 59A-36.011(9) FAC. Findings: Staff A, caregiver, was hired on ... Staff C, caregiver, was hired on ... Review of the personnel record for staff A & C did	AL243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/10/2021
---	--	---	--

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING SOUTHERN STYLE OF BREVARD LLC	1721 ROCKLEDGE DRIVE ROCKLEDGE, FL 32955

(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
AL243	Continued From page 35 not find any documentation they had completed the required 6 hours of LMH training. On at 1:45PM, the administrator confirmed she did not have any certificates for this training. Class III	AL243		
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain	CZ814		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
NAME OF PROVIDER OR SUPPLIER LIVING SOUTHERN STYLE OF BREVARD LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1721 ROCKLEDGE DRIVE ROCKLEDGE, FL 32955		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ814	Continued From page 36 a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on Agency background screen website review, personnel record review and interview, the facility failed to register and maintain the current employment status of employees within the Agency's Background Screening Clearinghouse within 10 days of hire for 2 of 5 sampled staff employees (D & E). Findings: 1. On _____ at 11:42AM, staff D stated she began working at the facility in _____. Review of the Agency's Background Screening Clearinghouse for the facility on _____ at 11:14 AM revealed staff D was not included on the facility's employee roster. 2. Staff E, was not listed on the current staff schedule. She was listed as a current employee on the facility's employment roster with a hire date of _____. On _____ at 1:45PM, the administrator confirmed staff D was hired in _____. She stated staff E no longer worked in the facility as of the end of _____. The administrator confirmed she had not updated the background screening roster for the facility. Unclassified	CZ814		
CZ815	408.809(1)(____); 435.02(2); 435.06 FS Background Screening; Prohibited Offenses	CZ815		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVING SOUTHERN STYLE OF BREVARD LLC

**1721 ROCKLEDGE DRIVE
ROCKLEDGE, FL 32955**

(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
CZ815	Continued From page 37 408.809 Background screening; prohibited offenses.- (1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are considered employees for the purposes of conducting screening under chapter 435: (a) The licensee, if an individual. (b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider. (c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider. (d) Any person who is a controlling interest. (e) Any person, as required by authorizing statutes, seeking employment with a licensee or provider who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, _____ with a licensee or provider whose responsibilities require him or her to provide personal care or personal services directly to clients, or _____ with a licensee or provider to work 20 hours a week or more who will have access to client funds, personal property, or living areas. Evidence of contractor screening may be retained by the contractor's employer or the licensee. (3) All _____ must be provided in electronic format. Screening results shall be reviewed by the agency with respect to the offenses specified in s. 435.04 and this section, and the qualifying or disqualifying status of the person named in the request shall be maintained in a database. The qualifying or disqualifying status of the person	CZ815		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVING SOUTHERN STYLE OF BREVARD LLC

**1721 ROCKLEDGE DRIVE
ROCKLEDGE, FL 32955**

(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
CZ815	Continued From page 38 named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee's behalf. (4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction: (a) Any authorizing statutes, if the offense was a felony. (b) This chapter, if the offense was a felony. (c) Section 409.920, relating to Medicaid provider fraud. (d) Section 409.9201, relating to Medicaid fraud. (e) Section 741.28, relating to domestic violence. (f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection. (g) Section 784.03, relating to battery, if the victim is a _____ adult as defined in s. 415.102 or a patient or resident of a facility licensed under chapter 395, chapter 400, or chapter 429. (h) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems. (i) Section 817.234, relating to false and fraudulent insurance claims. (j) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony. (k) Section 817.50, relating to fraudulently obtaining goods or services from a health care	CZ815		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
NAME OF PROVIDER OR SUPPLIER LIVING SOUTHERN STYLE OF BREVARD LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1721 ROCKLEDGE DRIVE ROCKLEDGE, FL 32955		
(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
CZ815	Continued From page 39 provider. (l) Section 817.505, relating to patient brokering. (m) Section 817.568, relating to criminal use of personal identification information. (n) Section 817.60, relating to obtaining a credit card through fraudulent means. (o) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony. (p) Section 831.01, relating to forgery. (q) Section 831.02, relating to uttering forged instruments. (r) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes. (s) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes. (t) Section 831.30, relating to fraud in obtaining medicinal drugs. (u) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony. (v) Section 895.03, relating to racketeering and collection of unlawful debts. (w) Section 896.101, relating to the Florida Money Laundering Act. If, upon rescreening, a person who is currently employed or _____ with a licensee and was screened and qualified under s. 435.04 has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption	CZ815		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
NAME OF PROVIDER OR SUPPLIER LIVING SOUTHERN STYLE OF BREVARD LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1721 ROCKLEDGE DRIVE ROCKLEDGE, FL 32955		
(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
CZ815	Continued From page 40 request is received by the agency no later than 30 days after receipt of the rescreening results by the person. (5) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening. (6)(a) As provided in chapter 435, the agency may grant an exemption from disqualification to a person who is subject to this section and who: - Does not have an active professional license or certification from the Department of Health; or - Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification. (b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may grant an exemption from disqualification to a person who is subject to this section and who has received a professional license or certification from the Department of Health or a regulatory board within that department and that person is providing a service within the scope of his or her licensed or certified practice. (7) The agency and the Department of Health may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, chapter 435, and authorizing statutes requiring background screening and to implement and adopt criteria relating to retaining _____ pursuant to s.	CZ815		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/10/2021
NAME OF PROVIDER OR SUPPLIER LIVING SOUTHERN STYLE OF BREVARD LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1721 ROCKLEDGE DRIVE ROCKLEDGE, FL 32955		
(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
CZ815	Continued From page 41 943.05(2). (8) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this section, terminates the person against whom the report was issued, whether or not that person has filed for an exemption with the Department of Health or the agency. 435.06 Exclusion from employment.- (1) If an employer or agency has reasonable cause to believe that grounds exist for the denial or termination of employment of any employee as a result of background screening, it shall notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity. (2)(a) An employer may not hire, select, or otherwise allow an employee to have contact with any person that would place the employee in a role that requires background screening until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of employment. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select, or otherwise allow the employee to have contact with any person that would place the employee in a role that requires background screening unless the employee is granted an exemption for the disqualification by the agency	CZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVING SOUTHERN STYLE OF BREVARD LLC

**1721 ROCKLEDGE DRIVE
ROCKLEDGE, FL 32955**

(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
CZ815	Continued From page 42 as provided under s. 435.07. (b) If an employer becomes aware that an employee has been _____ for a disqualifying offense, the employer must remove the employee from contact with any _____ person that places the employee in a role that requires background screening until the _____ is resolved in a way that the employer determines that the employee is still eligible for employment under this chapter. (c) The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of this chapter or place the employee in a position for which background screening is not required unless the employee is granted an exemption from disqualification pursuant to s. 435.07. (d) An employer may hire an employee to a position that requires background screening before the employee completes the screening process for training and orientation purposes. However, the employee may not have direct contact with _____ persons until the screening process is completed and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment. (3) Any employee who refuses to cooperate in such screening or refuses to timely submit the information necessary to complete the screening, including _____ if required, must be disqualified for employment in such position or, if employed, must be dismissed. (4) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages against, an employer that, upon notice of a conviction or _____ for a disqualifying offense listed under this chapter, terminates the person against whom the report	CZ815		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVING SOUTHERN STYLE OF BREVARD LLC

**1721 ROCKLEDGE DRIVE
ROCKLEDGE, FL 32955**

(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
CZ815	Continued From page 43 was issued or who was _____, regardless of whether or not that person has filed for an exemption pursuant to this chapter. 435.02 Definitions.-For the purposes of this chapter, the term: (2) "Employee" means any person required by law to be screened pursuant to this chapter, including, but not limited to, persons who are contractors, licensees, or volunteers. This Statute or Rule is not met as evidenced by: Based on personnel record review, Agency background screening website review and interview, the facility failed to ensure all staff had a level II background screening eligibility status for 2 of 4 sampled staff (A & D). Findings: 1. Review of the personnel file for staff A, caregiver hired _____, revealed a level 2 background screening eligibility result dated _____, which exceeds the 5-year validity window. Review of the Agency's background screening website on _____ at 10:35AM for staff A also revealed a status of "Agency Review Required." (photographic evidence obtained) 2. Review of the personnel record for staff D, caregiver hired _____, did not reveal any level 2 background screening eligibility. Review of the Agency's background screening website on _____ at 1:18PM for staff A revealed no matching records for the name and spelling provided by the administrator and staff D. (photographic evidence obtained) On _____ at 1:45PM, the administrator	CZ815		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVING SOUTHERN STYLE OF BREVARD LLC

**1721 ROCKLEDGE DRIVE
ROCKLEDGE, FL 32955**

(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
CZ815	Continued From page 44 confirmed the findings. Unclassified	CZ815		
CZ816	408.809(2) 435.05(2) 59A-35.090(2d-3b) Background Screening-Compliance Attestation 408.809 Background screening; prohibited offenses. - (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's _____ to the Federal Bureau of Investigation for a national criminal history record check unless the person's _____ are enrolled in the Federal Bureau of Investigation's national retained print notification program. If the _____ of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit _____ electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the _____ to the Federal Bureau of Investigation for a national criminal history record check. The _____ shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print _____ notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks	CZ816		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVING SOUTHERN STYLE OF BREVARD LLC

**1721 ROCKLEDGE DRIVE
ROCKLEDGE, FL 32955**

(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
CZ816	Continued From page 45 required by level 2 screening may be borne by the licensee or the person The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that: (a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section; (b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and (c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency. 435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers: (2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if for any of the disqualifying offenses while employed by the employer. 59A-35.090 Background Screening. (2) Processing Screening Requests, Required Documents and Fees. (d) An Attestation of Compliance with Background Screening Requirements, AHCA Form	CZ816		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
NAME OF PROVIDER OR SUPPLIER LIVING SOUTHERN STYLE OF BREVARD LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1721 ROCKLEDGE DRIVE ROCKLEDGE, FL 32955		
(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
CZ816	Continued From page 46 3100-0008, . . . , herein incorporated by reference, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-09106 , and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Service/s/Background_Screening/Regulations_Forms.shtml . This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if for any disqualifying offense. (e) An administrator or chief financial officer must be screened and qualified prior to to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal . (b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the report and court disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to Section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with Section 435.06(3), F.S.	CZ816		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVING SOUTHERN STYLE OF BREVARD LLC

**1721 ROCKLEDGE DRIVE
ROCKLEDGE, FL 32955**

(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
CZ816	Continued From page 47 This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to ensure 2 of 4 staff had signed the Affidavit of Compliance with Background Screening Requirements (C & D). Findings: 1. Review of the personnel record for staff C, caregiver hired , revealed a level 2 background screening eligibility dated . Continued review of the record did not find a signed attestation for compliance with the background screening requirements. 2. Review of the personnel record for staff D, caregiver hired , did not reveal a level 2 background screening eligibility. Continued review of the record did not find a signed attestation for compliance with the background screening requirements. On at 1:45 PM, the administrator confirmed the finding.	CZ816		