Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910711	A. BUILDING: _____ B. WING _____	06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR ASSISTED LIVING	2001 POLK STREET HOLLYWOOD, FL 33020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced Change of Ownership (CHOW), Focused . . . . Control and Generator Monitoring survey was conducted on through . . . . . at Midtown Manor Assisted Living. The facility had deficiencies related to the Change of Ownership (CHOW) survey.	A 000		
A 030	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; . . . . ., Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline,	A 030		

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A 030	Continued From page 1 1(800)96- . . . . or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident . . . . , neglect, and . ; 6. Administrative and housekeeping schedules and requirements; 7. . . . . control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible	A 030		

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A 030	Continued From page 2 telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . . . . . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . . . and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from	A 030		

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A 030	Continued From page 3 community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making . . . . . for health care services, the provision of or arrangement of transportation to health care . . . . . , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated	A 030		

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A 030	Continued From page 4 mentally . . . . . , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without . . . . . , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, ... , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder . . . . . Hotline operated by the Department of Children and Families, and, if applicable, ... , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State	A 030		

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A 030	Continued From page 5 Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide its residents a safe and decent living environment due to not having the adequate mattress coverings and	A 030		

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A 030	Continued From page 6 linens, for 39 out of 71 resident beds (Bed #1-#39). The findings are: In an interview with Resident #10 on /221 at 11:18AM, he stated he has not had sheets since the facility treated for bedbugs a few weeks ago. Surveyor observed resident's bed which only had a mattress , cover and no sheets or bedding. In an interview with Resident #11 on 06/014/2021 at 11:24AM, he stated he has not had his bed sheets for a while. Resident #11 did not elaborate or specify a time period that he has not had sheets. In an observation at this time, it was revealed that the bare mattress was dirty due to having no sheets. In an interview with Resident #3 on at 11:29AM he stated he had no bed sheets. Observation of Resident #3 confirmed that there were no sheets on his bed, only a mattress , cover on which he was laying at the time of interview. In an interview with Resident #13 on at 11:38AM, he stated he doesn't have any bed sheets since the facility's bug treatment a few weeks ago. Observation revealed that there were no bed sheets on the resident's bed and that the mattress , cover on which the resident was sleeping on presented to be soiled. In an interview with Resident #14 on at 11:48AM, he stated they don't have sheets on their beds. He further stated that his roommate had the same sheets on his bed for 2 weeks and that he was using sheets provided by his sister. Observation of the two beds in resident #14's	A 030		

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A 030	Continued From page 7 room revealed that the sheets on Resident 14's roommate's bed were crumpled in the middle of the bed and appeared soiled. In an interview with Resident #15 on [redacted] at 11:57AM, he stated he has not had sheets on his bed for over a month. Observation revealed that there were no sheets on the resident's bed. The resident stated that he is sleeping on the mattress cover, which appeared dirty during the observation. In an interview with Resident #16 on [redacted] on 12:03PM, she stated they don't have any sheets for their beds and that it's been like this for a month. Observation of resident's bed revealed that there were no sheets, only a mattress [redacted] cover. In an interview with Resident #17 on [redacted] at 12:15PM, he they don't have any sheets. He further stated he has his personal comforter that he uses, but no sheets. Observation of Resident's bed revealed that there are no sheets on the bed, only a mattress bed cover. In an interview with Resident #18 on [redacted] at 11:18AM, he stated they do not have any sheets on their beds. Observation of resident's bed revealed that there were no sheets on the bed, only a mattress [redacted] cover. Observation also revealed that his roommate had no sheets on his bed either. In an observation of [redacted] on [redacted] at 11:55AM, there were two beds inside this room. Observation revealed that there were no bed sheets or coverings on these two beds. The bare mattress on the bed on the South wall had dark granules around the seams of the mattress. The	A 030		

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A 030	Continued From page 8 Administrator was notified of this observation at this time and he ordered the mattress to be thrown away due to its condition. In an observation of on at 12:11PM, it was observed that both beds in this room had mattress covers but neither had bed sheets or linens of any kind (bed spread, comforter). In an interview with resident #4 on at 1:45pm, he stated that he didn't like to sleep on his bed which was bare and not covered with any linens or fitted sheets. He stated that his bed did not have any linens for several weeks. In an observation at this time inside resident #4's room (#101), it was noted that his bed had a bare mattress without any linens on it. In an interview with the manager on at 1:55pm, she stated that she was aware that resident #4's bed did not have an adequate mattress covering and linens. In an observation on at 10:55am inside # , it was noted that resident #4's bed had a bare mattress without any linens on it. In an interview with the administrator at this time, he stated that he was in process of getting new coverings and linens for all of the facility beds. He stated that he was aware that there were several resident beds which did not adequate coverings and linens on them. He stated that he will create a log to indicate which resident rooms and beds had missing coverings and linens. Review of the "linen encasement room tally" log provided by the administrator on indicated that there were 5 mattress coverings or encasements missing and 39 resident beds had	A 030		

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A 030	Continued From page 9 missing linens. Class III	A 030		
A 078	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 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	A 078		

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A 078	Continued From page 10 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 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 record review and interview, it was determined that the facility failed to ensure that facility staff received the required trainings; or required health statement for four (4) of four (4) staff members reviewed (MedTech A, Staff A, B and H). The Finding Include:	A 078		

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A 078	Continued From page 11 During Re-licensure Survey conducted on [redacted], a review of facility's employee files was conducted and revealed the following: a) A review of facility's employee file for Staff B indicated she was hired on [redacted] and works the 6:00 AM - 6:00 PM shift, is designated as a Resident Care Assistant (RCA) and provides direct care to residents. Further review of Staff H file indicated she did not have documented training in [redacted], and in [redacted] I and II as require for staff working in a facility that advertises and provides care for residents with [redacted] and Related [redacted] (ADRD). b) A review of facility's employee file for Staff A who was hired on [redacted] and works the 6:00 AM - 6:00 PM shift, did not have evidence of Pre-Service Orientation, or documentation from a health care professional that she is free of [redacted] ( ) and Communicable [redacted]. Review of Staff A file also revealed no evidence that she had received training in Nutrition and Safe Food Handling. Staff A was observed in the kitchen and dining room assisting with food preparation and serving lunch to residents during the lunch dining (between 12:00 PM and 1:00 PM) on [redacted] and [redacted]. In an interview with Staff A on [redacted] at 10:18 AM she stated she was hired as an MedTech but was assisting in the kitchen due to staff shortage. c) A review of facility's employee file for MedTech A who was hired on [redacted] revealed that she did not have evidence of Elopement Response Training in her file.	A 078		

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A 078	Continued From page 12 d) A review of facility's employee file for Staff H who was hired on [redacted] and works the 6:00 PM - 6:00 AM shift and provides assistance with Activities of Daily Living (ADL), did not contain evidence of training in providing assistance with ADL activities. Review of documents in her facility file also revealed that Staff H was hired as a Housekeeper, as reflected by her application and Position Description. However, review of facility's staff schedule indicates Staff H is designated as a Resident Care Assistant (RCA). Further review of Staff Hs record revealed Staff H did not have the following training: Assistance with Activities of Daily Living (ADL). Further review of Staff H file indicated she did not have documented training in [redacted], and in [redacted] I and II as require for staff working in a facility that advertises and provides care for residents with [redacted] 's [redacted] and Related [redacted] (ADRD). In an interview with the Administrator and Assistant Administrator on [redacted] at 11:45 AM, the Administrator did not provide information as to how long Staff H had been performing in the capacity of an RCA, therefore it could not be determined when the staff began working in the position of RCA. On [redacted] the Survey team met with Administrator and Assistant Administrator to conduct the Exit Interview. He was provided information regarding the findings. Specifically, the absence of documented trainings for MedTech A, Staff A, B and H in their files. Class III	A 078		

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A 083	Continued From page 13	A 083		
A 083	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 Record Review and Interview it was determined that the facility failed to ensure that a staff person with certification in First Aid and ( ) was present on all shifts for one (1) of one (1) staff reviewed (Staff H). The Findings Include: During review of employee file for Staff H who was hired on and works the 6:00 PM - 6:00 AM shift, and who may work alone during the shift as indicated by the facilities staff	A 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910711	A. BUILDING: _____ B. WING _____	06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN MANOR ASSISTED LIVING	2001 POLK STREET HOLLYWOOD, FL 33020

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A 083	Continued From page 14 schedule provided for . . . . . , . . . - . . . . . , did not have documentation of First Aid or . . training in her file. The staffing scheduled also indicated Staff H may work during the shift with another employee not certified in First and . . As a result, the facility does not have a person certified in First Aid and . . on duty at all times as required. In an interview with the Administrator and Assistant Administrator on . . . /2021 at 11:45 AM, the Administrator acknowledged that the RCAs working the night shift (6:00 PM - 6:00 AM) did not have certification in First Aid and . . He further stated that the RCAs were placed in the positions out of desperation resulting from a shortage of staff. On . . . . . , the Survey team met with Administrator to conduct the Exit Interview. He was provided information regarding the findings. Specifically, that Staff H who works the night shift and who may work alone (or with staff not certified in First and . .), did not have documentation of training in First Aid and . . . He was also informed that he would receive a report from our office with 10 business days. He acknowledged the findings. Class III	A 083		
A 152	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and,	A 152		

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A 152	Continued From page 15 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable 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 . This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that all mechanical, electrical and structural systems and appurtenances are maintained in good working order. As evidence of the facility failure to ensure its 2 elevators were adequately maintained and	A 152		

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A 152	Continued From page 16 be in good working order. The findings are: In an observation on at 10:30am in the facility's 3-level building located on the east side of the property, the elevator (BCID# 17043) had an expired certificate of operation, which indicated that it expired on . . and it was last inspected on . In an observation on . . at 11:15am in the facility's 3-level building located on the west side of the property, the elevator (BCID# 44148) had an expired certificate of operation, which indicated that it expired on . . and it was last inspected on . Review of the county elevator inspection report dated on . . . indicated that facility elevator BCID#17043 located in the east building had 2 violations relating to its alarm bell and machine room. Review of the county elevator inspection report dated on . . . indicated that facility elevator BCID#44148 located in the west building had 2 violations relating to its door reopening device and machine room. Further review of these county elevator inspection reports indicated that these violations must be corrected within 90 days and no proof of corrections by the facility was noted. Photo evidence of these reports was obtained. In an interview with the administrator . . at 11:30am, he stated that the elevator located in the east side of the facility property (BCID#17043) stopped working, it was stuck with its door partially opened at the 2nd level and 3 residents were initially inside the elevator when this happened earlier that morning. He stated that he was aware that the elevators had not received	A 152		

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A 152	Continued From page 17 adequate maintenance since the facility changed its ownership and were not presently certified by the county building code inspector. He stated that the facility recently with an elevator maintenance contractor so it can bring the 2 facility elevators up to code with the county building code inspections. Class III	A 152		
AL241	429.075( ); 59A-36.020(2) FAC LMH - Records 429.075 (3) A facility that has a limited mental health license must: (a) Have a copy of each mental health resident's community living support plan and the agreement with the mental health care services provider or provide written evidence that a request for the community living support plan and the agreement was sent to the Medicaid managed care plan or managing entity under contract with the Department of Children and Families within 72 hours after admission. The support plan and the agreement may be combined. (b) Have documentation provided by the department that each mental health resident has been assessed and determined to be able to live in the community in an assisted living facility that has a limited mental health license or provide written evidence that a request for documentation was sent to the department within 72 hours after admission. (c) Make the community living support plan available for inspection by the resident, the resident's legal guardian or health care surrogate, and other individuals who have a lawful basis for reviewing this document.	AL241		

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AL241	Continued From page 18 (d) Assist the mental health resident in carrying out the activities identified in the resident's community living support plan. (4) A facility that has a limited mental health license may enter into a [illegible] agreement with a private mental health provider. For purposes of the limited mental health license, the private mental health provider may act as the case manager. 59A-36.020 (2) RECORDS. (a) A facility with a limited mental health license must maintain an up-to-date admission and discharge log containing the names and dates of admission and discharge for all mental health residents. The admission and discharge log required in rule 59A-36.015, F.A.C., satisfies this condition provided that all mental health residents are clearly identified. (b) Staff records must contain documentation that designated staff have completed limited mental health training as required by rule 59A-36.011, F.A.C. (c) Resident records must include: 1. Documentation, provided by a mental health care provider within 30 days of the resident's admission to the facility, that the resident is a mental health resident as defined in section 394.4574, F.S., and that the resident is receiving social security [illegible], or supplemental security income and [illegible] as follows: a. An affirmative statement on the Alternate Care Certification for [illegible] ([illegible]) form, CF-ES 1006, [illegible], which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No	AL241		

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AL241	Continued From page 19 =Ref-03988, that the resident is receiving SSI or SSDI due to a mental , b. Written verification provided by the Social Security Administration that the resident is receiving SSI or SSDI for a mental . Such verification may be acquired from the Social Security Administration upon obtaining a release from the resident permitting the Social Security Administration to provide such information, or c. A written statement from the resident's case manager or other mental health care provider that the resident is an adult with severe and persistent mental . The case manager or other mental health care provider must consider the following minimum criteria in making that determination: (I) The resident is eligible for, is receiving, or has received mental health services within the last 5 years, or (II) The resident has been diagnosed as having a severe or persistent mental . 2. An appropriate placement assessment provided by the resident's mental health care provider within 30 days of admission to the facility that the resident has been assessed and found appropriate for residence in an assisted living facility. Such assessment must be conducted by a psychiatrist, clinical psychologist, clinical social worker, , nurse, or an individual supervised by one of these professionals. a. Any of the following documentation that contains the name of the resident and the name, signature, date, and license number, if applicable, of the person making the assessment, meets this requirement: (I) Completed Alternate Care Certification for , ( ) form, CF-ES Form 1006, (II) Discharge Statement from a state mental	AL241		

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AL241	Continued From page 20 hospital completed no more than 90 days before admission to the assisted living facility provided it contains a statement that the individual is appropriate to live in an assisted living facility, or (III) Other signed statement that the resident has been assessed and found appropriate for residency in an assisted living facility. b. A mental health resident returning to a facility from treatment in a hospital or crisis stabilization unit will not be considered a new admission and will not require a new assessment. However, a break in a resident's residency that requires the facility to execute a new resident contract or admission agreement will be considered a new admission and the resident's mental health care provider must provide a new assessment. 3. A Community Living Support Plan. Each mental health resident and the resident's mental health case manager must, in consultation with the facility administrator, prepare a plan within 30 days of the resident's admission to the facility or within 30 days after receiving the appropriate placement assessment in paragraph (2)(c), whichever is later, that: a. Includes the specific needs of the resident that must be met in order to enable the resident to live in the assisted living facility and the community, b. Includes the clinical mental health services to be provided by the mental health care provider to help meet the resident's needs, and the frequency and duration of such services, c. Includes any other services and activities to be provided by or arranged for by the mental health care provider or mental health case manager to meet the resident's needs, and the frequency and duration of such services and activities, d. Includes the [illegible] of the facility to facilitate and assist the resident in attending [illegible] and arranging transportation to	AL241		

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AL241	Continued From page 21 . . . . . for the services and activities identified in the plan that have been provided or arranged for by the resident's mental health care provider or case manager, e. Includes a description of other services to be provided or arranged by the facility, f. Includes a list of factors pertinent to the care, safety, and welfare of the mental health resident and a description of the signs and symptoms , to the resident that indicate the immediate need for professional mental health services, g. Is in writing and signed by the mental health resident, the resident's mental health case manager, and the assisted living facility administrator or manager and a copy placed in the resident's file. If the resident refuses to sign the plan, the resident's mental health case manager must add a statement that the resident was asked but refused to sign the plan, h. Is updated at least annually or if there is a significant change in the resident's behavioral health, i. , include the , Agreement described in subparagraph (2)(c)4. If included, the mental health care provider must also sign the plan; and, j. Must be available for inspection to those who have legal authority to review the document. 4. , Agreement. The mental health care provider for each mental health resident and the facility administrator or designee must prepare a written statement, within 30 days of the resident's admission to the facility or receipt of the resident's appropriate placement assessment, whichever is later. The statement: a. Provides procedures and directions for accessing emergency and after-hours care for the mental health resident. The provider must	AL241		

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AL241	Continued From page 22 furnish the resident and the facility with the provider's 24-hour emergency crisis telephone number; b. Must be signed by the administrator or designee and the mental health care provider, or by a designated representative of a Medicaid prepaid health plan if the resident is on a plan and the plan provides behavioral health services in section 409.912, F.S.; c. , cover all mental health residents of the facility who are clients of the same provider; and, d. , be included in the Community Living Support Plan described in subparagraph (2)(c)3. 5. Missing documentation 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 appropriate party. A documented request for such missing documentation made by the facility administrator within 72 hours of the resident's admission will be considered a good faith effort. The documented request must include the name, title, and phone number of the person to whom the request was made and must be kept in the resident's file. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have a copy of the community living support plan (CLSP) and , agreement ( ) for 2 out of 2 sampled limited mental health (LMH) residents (residents #3 and 8). The findings are: Review of facility's admit/discharge log indicated resident #3 was a LMH resident and was admitted to the facility on . Further review of this log indicated that resident #8 was a LMH resident and was admitted to the facility on	AL241		

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AL241	Continued From page 23 . . . . . Review of resident #3's health assessment dated on indicated that he was diagnosed with adjustment , , high and . Review of this health assessment indicated that the resident was independent with all of his activities of daily living (ADLs), with exception to grooming to which he needed supervision. Further review of this health assessment indicated that the resident also needed assistance with self-administration with his daily medications. Review of the resident's record indicated that there was no LMH documentation available for review, including the resident's CLSP or . . Review of resident #8's health assessment dated on indicated that he was diagnosed with , right , and cord injury due to . Review of this health assessment indicated that the resident was independent with ambulation and eating, and needed supervision with toileting and assistance with transfers, , and bathing. Further review of this health assessment indicated that the resident also needed assistance with self-administration with his daily medications. Review of the resident's record indicated that there was no LMH documentation available for review, including the resident's CLSP or . . In an interview with the administrator on at 12:15pm, he stated that the facility did not ensure to have residents #3 and 8 complete with all of their LMH documentation. He stated that the facility was in process to develop these residents' documents with their mental health	AL241		

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AL241	Continued From page 24 providers. In an interview with the administrator on . at 1:20pm, he stated that the facility did not have residents # 3 and 8's completed CLSPs or CAs for review. Class III	AL241		
AL243	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 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	AL243		

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AL243	Continued From page 25 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; (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	AL243		

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AL243	Continued From page 26 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 Record Review, Observation the facility failed to ensure that three (3) of four (4) residents reviewed (MedTech A, Staff A and Staff B) received the 6 hours of Limited Mental Health (LMH) training within 6 months of hire. The Findings Include: During Re-licensure visit on . . . . . - review of Staff files was conducted. During review on . . . . . observation revealed no documentation of Limited Mental Health (LMH) training for MedTech A who began employment on . Staff A who was hired on . . . . . , and Staff B who was hired on . During Exit interview with the Administrator and Assistant Administrator on . . . . . they were informed of the findings, which included failure to ensure reviewed staff received LMH training as required. They were also informed that they will receive a report from our office within ten (10) business days. Class III	AL243		

Agency for Health Care Administration

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to include 1 out of 4 sampled employees (Staff C) in its background screening (BGS) employee roster. The findings are:	CZ814		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910711	A. BUILDING: _____ B. WING _____	06/17/2021

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CZ814	Continued From page 28 Review of the facility records indicated that Staff C was not listed in the facility's BGS employee roster. Further review of Staff C's employee record indicated that she was hired at the facility on in a capacity to perform food and nutrition services for the residents and to provide related direct care to the residents. In an interview with the Administrator on at 1:00pm, he stated that Staff C performed personal care services to the residents as part of her daily tasks and that he didn't know reason why Staff C was not listed in the facility's BGS roster. Unclassified	CZ814		
CZ830	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30	CZ830		

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CZ830	Continued From page 29 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning	CZ830		

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CZ830	Continued From page 30 and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure that their Comprehensive Emergency Management Plan (CEMP) was submitted and approved by the Local County Emergency Management Division. Findings Include: During Re-licensure Survey conducted on - a review of the facility's Comprehensive Emergency Management Plan (CEMP) was conducted. During review	CZ830		

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CZ830	Continued From page 31 observation was made of an approved CEMP letter from the local Emergency Management Division dated . . . . . indicated an approval which expired on . In addition, the approval was granted to previous ownership. In an interview with Administrator on . . . . . at 11:05 AM he stated the CEMP has not been submitted, and that he has been lax. He further stated that with all that is going on at the facility, he just did not get to it. During the interview, the Administrator was reminded that approval granted was for previous ownership is not transferable, and that a new approval was required anytime there is a substantial change, which a change of ownership constitutes. And that the emergency management plan must be submitted for review and approval to the local Emergency Management for facilities whose ownership has been transferred within 60 days of the provisional license. He acknowledged the findings as stated he will get to it. During the Exit interview with the Administrator and Assistant Administrator on they were informed of the findings, which included failure to timely secure approval of their CEMP. Class III	CZ830		