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
	AL11964891	A. BUILDING: _____ B. WING _____	06/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEURORESTORATIVE FLORIDA (WHITNEY ACRES)	2769 WHITNEY ROAD CLEARWATER, FL 33760

(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 Extended Congregate Care Monitoring survey was conducted at NeuroRestorative Florida Whitney Acres Assisted Living Facility on . . . . The facility had deficiencies at the time of the survey.	A 000		
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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964891	A. BUILDING: _____ B. WING _____	06/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEURORESTORATIVE FLORIDA (WHITNEY ACRES)	2769 WHITNEY ROAD CLEARWATER, FL 33760

(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 1 429.174, 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 [redacted] 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 record review and interview the facility failed to maintain personnel records for each staff member which contain, at a minimum, documentation of background screening and documentation of compliance with all training for all staff employed in the facility. Findings Included: An entrance interview conducted on at 3:15p.m with the Case Manager she stated um! Yes, the Administrator just walked in, I am getting them.	A 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964891	A. BUILDING: _____ B. WING _____	06/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEURORESTORATIVE FLORIDA (WHITNEY ACRES)	2769 WHITNEY ROAD CLEARWATER, FL 33760

(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 2 An interview on ..... at 3:25 p.m. with the Case manager she stated, employee records you must ask the Administrator. An interview on ..... at 3:29 p.m. with the administrator he stated our employee charts are not here we have them in a centralized office, we must request them, and they are faxed. They are not accessible to be seen on the computer. An observation and record review conducted on at 4:15pm The Administrator was not able to provide Employee records. Class III	A 161		
AE205 SS=D	59A-36.021(5); 429.07 (3)(b) ECC - Health Assessment 59A-36.021 (5) HEALTH ASSESSMENT. Before receiving extended congregate care services, all persons. including residents transferring within the same facility to that portion of the facility licensed to provide extended congregate care services, must be examined by a health care provider pursuant to rule 59A-36.006, F.A.C. A health assessment conducted no more than 60 days before receiving extended congregate care services meets this requirement. Once receiving services, a new health assessment must be obtained at least annually. 429.07 (3)(b), FS 6. Before the admission of an individual to a facility licensed to provide extended congregate care services, the individual must undergo a medical examination as provided in s. 429.26(4) and the facility must develop a preliminary service	AE205		

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
	AL11964891	A. BUILDING: _____ B. WING _____	06/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEURORESTORATIVE FLORIDA (WHITNEY ACRES)	2769 WHITNEY ROAD CLEARWATER, FL 33760

(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
AE205	Continued From page 3 plan for the individual. 7. If a facility can no longer provide or arrange for services in accordance with the resident's service plan and needs and the facility's policy, the facility must make arrangements for relocating the person in accordance with s. 429.28(1)(k). This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to provide an Initial health Assessments completed at least 60 days prior to Resident #1 receiving extended congregate care and failed to obtain annual heath assessments. Finding Included: A record review conducted for Resident #1 revealed there was no initial Health Assessment 1823 and no annual Assessments found in Residents medical chart. An interview conducted on at 3:29 p.m. with the administrator he stated I know the Health Assessments was updated since then, I will get with my nurse. An observation made on at 3:29p.m. The Administrator was observed revising residents medical record for Health Assessments, no documents found, left chart at 3:40 pm. An interview conducted on at 3:48 p.m. with the Administrator he stated so, I was looking for the initial assessments and I spoke to my nurse she said was told on the last survey that she did not have to keep the initial assessment so that was sent to the file in the storage. An interview conducted on at 3:53 p.m. with the Administrator he stated the resident	AE205		

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
	AL11964891	A. BUILDING: _____ B. WING _____	06/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEURORESTORATIVE FLORIDA (WHITNEY ACRES)	2769 WHITNEY ROAD CLEARWATER, FL 33760

(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
AE205	Continued From page 4 (Resident #1) has a recent 2020 , Health Assessment 1823 ,the initial must have been thinned out. Class III	AE205		
AE206 SS=D	59A-36.021(6) FAC ECC - Service Plans (6) SERVICE PLANS. (a) Before receiving services, the extended congregate care administrator or manager must develop a preliminary service plan that includes an assessment of whether the resident meets the facility's residency criteria, an appraisal of the resident's unique physical, [illegible] and social needs and preferences, and an evaluation of the facility's ability to meet the resident's needs. (b) Within 14 days of receiving services, the extended congregate care administrator or manager must coordinate the development of a written service plan that takes into account the resident's health assessment obtained pursuant to subsection (6); the resident's unique physical, [illegible] and social needs and preferences; and how the facility will meet the resident's needs including the following if required: 1. Health monitoring, 2. Assistance with personal care services, 3. Nursing services, 4. Supervision, 5. Special diets, 6. Ancillary services, 7. The provision of other services such as transportation and supportive services; and, 8. The manner of service provision, and identification of service providers, including family and friends, in keeping with resident preferences. (c) Pursuant to the definitions of "shared	AE206		

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
	AL11964891	A. BUILDING: _____ B. WING _____	06/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEURORESTORATIVE FLORIDA (WHITNEY ACRES)	2769 WHITNEY ROAD CLEARWATER, FL 33760

(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
AE206	Continued From page 5 responsibility" and "managed risk" as provided in section 429.02, F.S., the service plan must be developed and agreed upon by the resident or the resident's representative or designee, surrogate, guardian, or attorney-in-fact, and must reflect the responsibility and right of the resident to consider options and assume risks when making choices pertaining to the resident's service needs and preferences. (d) The service plan must be reviewed and updated quarterly to reflect any changes in the manner of service provision, accommodate any changes in the resident's physical or mental status, or pursuant to recommendations for modifications in the resident's care as documented in the nursing assessment. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to review and update Service plans quarterly to reflect any changes in the manner of service provision, accommodate any changes in the resident's physical or mental. status for one (Resident #1) of one resident sampled. Finding included: A Record Review conducted on for Resident #1 revealed an initial Service Plan dated , last updated 2018. An interview conducted on at 3:25 p.m. with the Case Manager she stated our nurse called out sick today. An interview conducted on at 3:29 p.m. with the administrator he stated I know the service plan was updated since then, I will get	AE206		

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
	AL11964891	A. BUILDING: _____ B. WING _____	06/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEURORESTORATIVE FLORIDA (WHITNEY ACRES)	2769 WHITNEY ROAD CLEARWATER, FL 33760

(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
AE206	Continued From page 6 with my nurse. An observation made on [redacted] at 3:29p.m. The Administrator was observed revising residents medical record for updated Service plan, no documents found, left chart at 3:40 pm. Class III	AE206		