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
	AL11967199	A. BUILDING: _____ B. WING _____	R 07/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA BONITA ALF LLC	931 NE 17 TERRACE HOMESTEAD, FL 33033

(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 COVID-19 monitoring revisit was conducted at Casa Bonita ALF, LLC on [redacted] and concluded on [redacted]. Deficiencies were identified at the time of the survey.	{A 000}		
{A 010} SS=G	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the	{A 010}		

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{A 010}	Continued From page 1	{A 010}		

resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care.
(d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to:
a. Move, turn, or reposition without total physical assistance;
b. Transfer to a chair or wheelchair without total physical assistance; or
c. Sit safely in a chair or wheelchair without personal assistance or a physical . . . .
2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days.
3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days.
(2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident ' s representative or designee or the resident ' s family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.
(3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial

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{A 010}	Continued From page 2 examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 59A-36.002, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days. (b) A resident requiring care of a , may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care provider, the resident must be discharged from the facility. (c) A ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions	{A 010}		

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{A 010}	Continued From page 3 are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the appropriateness of continued residency for one out of five (Resident #1) sampled residents.	{A 010}		

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{A 010}	Continued From page 4 Resident #1 had a history of eloping from the facility, aggressive behavior towards residents and staff, stealing from other residents, screaming, and not complying with his medication. The facility allowed Resident #1 to be without medical care until the resident became and aggressive. Findings included: Review of Resident's #1 progress revealed the resident screamed to the staff, stole objects from other residents, did not sleep at night, entered other resident's rooms, was aggressive and annoyed towards residents and staff. The resident came in the middle of the night at 3:00 PM from his girlfriend's house. The resident slept all day on . Review of Resident # 1's police report dated showed a narrative by the police officer "I was dispatched to address to recover a missing person. Upon arrival I contacted the Administrator. Administrator told me that she owns an Assisted Living Facility (ALF) and one of her residents, Resident #1 had been reported as missing by police department. Administrator located Resident #1 at this location." In an interview on at 11:40 AM, Resident #2, roommate of Resident #1, stated Resident #1 did not like to live in the facility. He said the Resident left the facility the day before and went to Oklahoma. He stated the resident left the facility in the past and always came . In an interview on at 12:25 PM, the administrator stated Resident #1 did not elope. She said Resident #1 was discharged to his girlfriend's house and was at the hospital. She	{A 010}		

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{A 010}	Continued From page 5 said she went to the resident's girlfriend's house to see him and brought him his medications the day before. The administrator stated the facility documented Resident #1's behavior in his record after he left. She said no one informed her that the resident was stealing from other residents, screaming, and had aggressive behavior towards residents and staff. She stated the resident's psychiatrist saw the resident in the facility every month, and the last time he was seen by his psychiatrist was the Friday before he left Friday. She said she contacted Resident's #1 physician several times to obtain the prescription for home health services for the resident. The administrator stated the resident did not receive the medication , 25 MG/ML in and , because the physician did not send the prescription for home health services. In an interview on at 12:28 PM, when asked where she took Resident #1's The administrator did not know the resident's girlfriend's address and could not explain why the resident's medications were still in the facility. In an interview conducted on at 2:45 PM, Resident #1's psychiatrist stated Resident #1 never was at the facility when she visited him. She said she went to the facility last Friday, but he was not there. She only saw the resident when he was at the hospital last month. She said the facility's owner told her that the resident goes out every day. She said he received the medication , 25 MG/ML at the hospital, and she prescribed the medication for him at the facility, but the resident did not receive it. She said she could not coordinate the outpatient home health services because the resident never was at the facility when she visited him.	{A 010}		

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{A 010}	Continued From page 6 Observation of Resident's #1 medications showed two unopened vials of [redacted] 25 MG/ML received on [redacted] and [redacted]. A review of Food and Drug Administration data showed that [redacted] is used to treat specific mental/ [redacted] problems ([redacted]). The medications reduced episodes of [redacted], or bizarre behaviors that occur in patients with [redacted]. A review of Resident #1's hospital record showed the resident was involuntarily hospitalized under the [redacted] and [redacted] on [redacted] after he had been gone for several days. The resident's physician documented that the police and a state agency were involved. The resident was brought to the hospital on [redacted] at 9:39 PM for an evaluation of [redacted] and was diagnosed with [redacted] intoxication. The resident reported failing today with loss of [redacted] for unknown duration. The resident stated he drinks multiples bottles of champagne daily, and the last drink was early in the afternoon. The resident reported he was recently discharged from the hospital for evaluation after he [redacted] from the bike. A review of the state agency incident report database showed that no record regarding the occurrence. A review of Resident #1's health assessment dated [redacted] showed a medical history and diagnoses of [redacted] and [redacted]. The health assessment	{A 010}		

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{A 010}	Continued From page 7 documented the resident needed assistance with his physical/sensory limitations, was alert with his [illegible]/behavioral status and showed the resident was at an elopement risk. The physician indicated the resident was also independent with all activities of daily living. There was no documentation of any attempts the facility made to contact Resident's #1 psychiatrist regarding the home health services. Class II Uncorrected	{A 010}		
A 027	59A-36.007(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making [illegible] and remind residents about scheduled [illegible] for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation. (c) The facility may not require residents to receive services from a [illegible] health care provider. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the residents received the medical care they needed for one	A 027		

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A 027	Continued From page 8 out of five (Resident #1) sampled residents. The facility allowed Resident #1 to be without medical care for two months. The facility failed to contact the healthcare provider after Resident #1 returned from the hospital, to receive his treatment at the facility. Resident #1 did not receive his prescribed medication for two months, and the resident became aggressive towards residents and staff. Findings Included: Observation of Resident's #1 medications showed two unopened vials of , 25 MG/ML received on and . A review of webmd.com showed that is used to treat specific mental/ problems (,). The medications reduced episodes of , , or bizarre behaviors that occur in patients with , . Review of Resident #1's health assessment dated showed a medical history and diagnoses of , , , , , , and , . The health assessment documented the resident needed assistance with his physical/sensory limitations, was alert with his /behavioral status and showed the resident was at an elopement risk. The physician indicated resident was also independent with all activities of daily living. A review of Resident's #1 progress revealed the resident screamed to the staff, stole objects from other residents, did not sleep at night, entered other resident's rooms, was aggressive and	A 027		

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A 027	Continued From page 9 annoyed towards residents and staff. The resident came in the middle of the night at 3:00 PM from his girlfriend's house. The resident slept all day on . In an interview on at 12:25 PM, the administrator stated that Resident #1 was at the hospital. She said she went to the Resident's girlfriend's house to see him and brought him his medications yesterday. The administrator stated they documented Resident's #1 behavior in his record after he left yesterday. She stated that she did not know the resident was stealing from other residents, screaming, and had aggressive behavior towards residents and staff. She said the resident , , saw the resident in the facility every month, and the last time he was seen by his psychiatrist was last Friday. She said stated she contacted the Resident's #1 physician several times to obtain the prescription for the home health services. The administrator confirmed the resident did not receive the medication , ... 25 MG/ML in and , because the physician did not send the prescription for home health services. The administrator did not know the resident's girlfriend's address and could not explain why the resident's medications were still in the facility. In an interview conducted on . . . . . at 2:45 PM, Resident #1's psychiatrist stated that the resident never was at the facility when she visited him. She said she went to the facility last Friday, but he was not there. She only saw the resident when he was at the hospital last month. She said the facility's owner told her that the resident goes out every day. She said he received the medication , ... 25 MG/ML at the hospital, and she prescribed the medication	A 027		

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A 027	Continued From page 10 for him at the facility, but the resident did not receive it. She said she could not coordinate the outpatient home health services because the resident never was at the facility when she visited him. There was no documentation of any attempts the facility made to contact resident's #1 psychiatrist regarding the home health services. A review of Resident #1's hospital record showed the resident was admitted [redacted] and [redacted] on [redacted] after was gone for several days. The resident's physician document that the police and a state agency were involved. The resident was brought to the hospital on [redacted] at 9:39 PM for an evaluation of [redacted] and was diagnosed with intoxication. The resident reported failing today with loss of [redacted] for unknown duration. The resident stated he drinks multiples bottles of champagne daily, and the last drink was early in the afternoon. The resident reported he was recently discharged from the hospital for evaluation after he [redacted] from the bike. A review of the state agency database showed that no record regarding the incident was filed. Class II	A 027		
{A 032} SS=H	59A-36.007(8) FAC Resident Care - Elopement Standards 59A-36.007 (8) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified	{A 032}		

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{A 032}	Continued From page 11 so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and	{A 032}		

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{A 032}	Continued From page 12 premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to sections 429.41(1)(a)3. and 429.41(1)(l), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to follow it's procedures regarding elopement. One out of five (Resident #1) sampled residents who had a history of eloping from the facility multiple times did not have an elopement prevention plan . The resident eloped from the facility nd was found hospitalized his hospital admission on _____ and left the facility on _____, and was transferred to the hospital two hours later with _____ intoxication. Findings Include: Review of Resident #1's police report dated _____ showed a narrative by the police officer "I was dispatched to address to recover a missing person. Upon arrival I contacted the Administrator. The Administrator told me that she owns an Assisted Living Facility (ALF), and one of her residents, Resident # 1, was reported as	{A 032}		

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{A 032}	Continued From page 13 missing by the police department. Administrator located Resident # 1 at this location." Review of Resident #1's hospital record showed the resident was admitted and on after was gone for several days. The resident's physician document that the police and a state agency were involved. The resident was brought to the hospital on at 9:39 PM for an evaluation of and was diagnosed with intoxication. The resident reported failing today with loss of for unknown duration. The resident stated he drinks multiples bottles of champagne daily, and the last drink was early in the afternoon. The resident reported he was recently discharged from the hospital for evaluation after he from a bike. A review of a state agency database showed that no record regarding the incident. Review of Resident #1's health assessment dated showed a medical history and diagnoses of , and . The health assessment documented the resident needed assistance with his physical/sensory limitations, was alert with his /behavioral status and showed the Resident was at an elopement risk. The physician indicated the resident was also independent with all activities of daily living. In an interview on at 11:40 AM, Resident #2, roommate of Resident #1, stated Resident #1 did not like to live in the facility. He said the Resident left the facility the day before and went to Oklahoma. He stated the resident left the facility in the past and always come .	{A 032}		

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	AL11967199	A. BUILDING: _____ B. WING _____	R 07/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A 032}	Continued From page 14 In an interview on at 12:25 PM, the administrator stated Resident #1 did not elope. She said Resident #1 was discharged to his girlfriend's house and was at the hospital. She said she went to the resident's girlfriend's house to see him and brought him his medications the day before. In an interview on at 1:02 PM, Staff D stated Resident #1 took his medications around 6:15 PM and left to his girlfriend's house at 7:30 PM. She said, "He used to go to his girlfriend's house after he took his medications and returned at night every day. Resident's girlfriend called the facility when he was in her house. She said resident's #1 girlfriend did not call her yesterday. On , the facility conducted a risk assessment for Resident #1. The report indicated the Resident was at risk of . Review of the facility's "Elopement Policies and Procedures" showed the facility would "Notify the police department, health care provider and family member or guardian that a resident is missing within one hour of incident or after the immediate search is completed, whichever is sooner." No documentation showed the facility implemented any preventative measure to prevent the residents from eloping. Uncorrected Class III	{A 032}		

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{A 165}	Continued From page 15	{A 165}		
{A 165} SS=D	429.23(&) FS; 59A-36.016 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident ' s condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1	{A 165}		

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{A 165}	Continued From page 16 business day after the occurrence of an adverse incident, through the agency ' s online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility ' s investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency ' s online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility ' s investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or	{A 165}		

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{A 165}	Continued From page 17 through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. 59A-36.016 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1), above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to submit an adverse incident report within one business day and within 15 days of the incident to the Agency for Healthcare Administration (AHCA) for two out of five (Resident #1) sampled residents. Resident # 1 eloped from the facility and was sent to the hospital [redacted] and [redacted] in	{A 165}		

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{A 165}	Continued From page 18 Findings Include: A review of the online Adverse Incident Reporting System database showed no documentation that the facility filed a one-day and a 15-day report regarding Resident #1 elopement that happened before the resident was admitted to the hospital on . A review of Resident #1's hospital record showed the resident was admitted on . The resident was and , on after was gone for several days. The resident's physician document that the police and another state agency were involved. A review of Resident #1's record showed no documentation that the resident eloped from the facility in . A review of the online database showed no record regarding the incident reported to the state agency. In an interview on at 1:19 PM, Administrator stated that she needed to review Resident's #1 progress notes. She said the facility submitted the adverse incident for the elopement that happened on . Uncorrected Class III	{A 165}		
A 190 SS=D	59A-36.023( ) & (3)(b); 429.14( ) Administrative Enforcement 59A-36.023( ) & (3)(b) FAC Facility staff must cooperate with agency	A 190		

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A 190	Continued From page 19 personnel during surveys, complaint investigations, monitoring visits, license application and renewal procedures and other activities necessary to ensure compliance with Part II, Chapter 408, F.S., Part I, Chapter 429, F.S., Rule Chapter 59A-35, F.A.C., and this rule chapter. 429.41(5) The agency may use an abbreviated biennial standard licensure inspection that consists of a review of key quality-of-care standards in lieu of a full inspection in a facility that has a good record of past performance. However, a full inspection must be conducted in a facility that has a history of class I or class II violations, uncorrected class III violations; or a class I, Class II, or uncorrected class III violation resulting from a complaint referred by the State Long-Term Care Ombudsman Program, within the previous licensure period immediately preceding the inspection or if a potentially serious problem is identified during the abbreviated inspection. (1) Abbreviated Survey. (a) An applicant for license renewal who does not have any class I or class II violations or uncorrected class III violations, or a class I, class II, or uncorrected class III violation resulting from a complaint referred by the State Long-Term Care Ombudsman Program within the two licensing periods immediately preceding the current renewal date, is eligible for an abbreviated biennial survey by the agency. Facilities that do not have two survey reports on file with the agency under current ownership are not eligible for an abbreviated inspection. Upon arrival at the facility, the agency must inform the facility that it is eligible for an abbreviated survey, and that an abbreviated survey will be conducted. (b) Compliance with key quality of care standards	A 190		

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A 190	Continued From page 20 described in the following statutes and rules will be used by the agency during its abbreviated survey of eligible facilities: 1. Section 429.26, F.S., and Rule 58A-5.0181, F.A.C., relating to residency criteria; 2. Section 429.27, F.S., and Rule 58A-5.021, F.A.C., relating to proper management of resident funds and property; 3. Section 429.28, F.S., and Rule 58A-5.0182, F.A.C., relating to respect for resident rights; 4. Section 429.41, F.S., and Rule 58A-5.0182, F.A.C., relating to the provision of supervision, assistance with the activities of daily living, and arrangement for and transportation to ; 5. Section 429.256, F.S., and Rule 58A-5.0185, F.A.C., relating to assistance with or administration of medications; 6. Section 429.41, F.S., and Rule 58A-5.019, F.A.C., relating to the provision of sufficient staffing to meet resident needs; 7. Section 429.41, F.S., and Rule 58A-5.020, F.A.C., relating to minimum dietary requirements and proper food hygiene; 8. Section 429.075, F.S., and Rule 58A-5.029, F.A.C., relating to mental health residents' community support living plan; 9. Section 429.07, F.S., and Rule 58A-5.030, F.A.C., relating to meeting the environmental standards and residency criteria in a facility with an extended congregate care license; and 10. Section 429.07, F.S., and Rule 58A-5.031, F.A.C., relating to the provision of care and staffing in a facility with a limited nursing services license. (c) The agency will expand the abbreviated survey or conduct a full survey if violations which threaten or potentially threaten the health, safety, or welfare of residents are identified during the	A 190		

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A 190	Continued From page 21 abbreviated survey. The facility must be informed when a full survey will be conducted. If one or more of the following serious problems are identified during an abbreviated survey, a full biennial survey will be immediately conducted: 1. Violations of Rule Chapter 69A-40, F.A.C., relating to fire safety, that threaten the life or safety of a resident; 2. Violations relating to staffing standards or resident care standards that adversely affect the health, safety, or welfare of a resident; 3. Violations relating to facility staff rendering services for which the facility is not licensed; or 4. Violations relating to facility medication practices that are a threat to the health, safety, or welfare of a resident. (2) Survey Deficiency. (a) Before or in conjunction with a notice of violation issued pursuant to Part II, Chapter 408, F.S., and Section 429.19, F.S., the agency shall issue a statement of deficiency for class I, II, III, and violations which are observed by agency personnel during any inspection of the facility. The deficiency statement must be issued within 10 working days of the agency's inspection and must include: 1. A description of the deficiency; 2. A citation to the statute or rule violated; and 3. A time frame for the correction of the deficiency. (b) Additional time may be granted to correct specific deficiencies if a written request is received by the agency before the expiration of the time frame included in the agency's statement. (3(b) Dietary Deficiencies. 1. If a class I, class II, or uncorrected class III	A 190		

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A 190	Continued From page 22 deficiency directly related to dietary standards as established in Rule 58A-5.020, F.A.C., is documented by agency pursuant to an inspection of the facility, the agency must notify the facility in writing that the facility must employ or contract the services of a registered or licensed dietitian, or a licensed nutritionist. 2. The initial on-site consultant visit must take place within seven working days of the notice of a class I or II deficiency or within 14 working days of the notice of an uncorrected class III deficiency. The facility must have available for review by the agency a copy of the license or registration of the consultant dietitian or nutritionist and the consultant's signed and dated review of the facility's corrective action plan, if a plan is required by the agency, no later than 10 working days after the initial on-site consultant visit. 3. If a corrective action plan is required, the facility must provide the agency with, at a minimum, quarterly on-site corrective action plan updates until the agency determines after written notification by the dietary consultant and facility administrator, that deficiencies are corrected and staff has been trained to ensure that proper dietary standards are followed and consultant services are no longer required. The agency must provide the facility with written notification of such determination. 429.14 (6) As provided under s. 408.814, the agency shall impose an immediate moratorium on an assisted living facility that fails to provide the agency with access to the facility or prohibits the agency from conducting a regulatory inspection. The licensee may not restrict agency staff from accessing and copying records at the agency's	A 190		

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A 190	Continued From page 23 expense or from conducting confidential interviews with facility staff or any individual who receives services from the facility. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain the records readily available for review for two out of five (Resident #1 and #2) sampled residents. Findings Include: A review of Resident's #1 and #2's Medication Observation Records (MOR) showed no documentation of the MOR for . . . . . . In an interview on at 12:25 PM, the Administrator stated she left the records in her consultant's office. Class III	A 190		