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
	AL11953542	A. BUILDING: _____ B. WING _____	C 09/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALMS OF LONGWOOD (THE)	480 EAST CHURCH AVENUE LONGWOOD, FL 32750

(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 160 SS=D	59A-36.015(1) FAC Records - Facility The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a [redacted]; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of [redacted]. (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as	A 160		

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A 160	Continued From page 1 described in rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in rule 59A-36.007, F.A.C. (j) All food service records required in rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to section 429.41, F.S., and rule chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to section 381.031, F.S., and chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years.	A 160		

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A 160	Continued From page 2 (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure accurate and up-to-date admission-discharge log was maintained, and included the information as required pursuant to 59A-36.015(1) FAC. Findings: Upon entry to the facility on .. .. , caregivers reported there were 58 residents in the facility. An admission and discharge log were provided. Review of the log found it contained admission dates or discharge dates between and .. .. . Each line item in the spreadsheet contained either an admission or discharge date. Current residents living in the facility on .. .. who were admitted prior to were not listed anywhere. Several current residents were documented as having been discharged. Several residents were listed with multiple admission and discharge dates. Photographic evidence was obtained. On .. .. at 10:30AM, the interim director stated that was the only log she had available. She confirmed many residents were listed as discharged who were still living in the facility and	A 160		

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A 160	Continued From page 3 not all current residents were in the log. Class III	A 160		
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 429.174, F.S., and rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or	A 161		

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A 161	Continued From page 4 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 personnel record request and interview, the facility failed to retain the personnel record for 1 of 13 staff records (L). Findings: Request to the review the personnel record for staff L, former administrator, found the facility did not have a record available for review. On [redacted] at 2:30 PM, the marketing director, appointed as interim director as of [redacted], confirmed the previous administrator left the facility on [redacted] and said there was no record available for review. Class III	A 161		

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A 162	Continued From page 5	A 162		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. [illegible], 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance [illegible], 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, [illegible], or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C. (f) A [illegible] record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their [illegible] recorded semi-annually.	A 162		

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A 162	Continued From page 6 (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S. (l) If the resident is an . . . recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , ... ' ' ( ), CF-ES 1006, . . , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy,	A 162		

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A 162	Continued From page 7 guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's . . . . . , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020,	A 162		

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A 162	Continued From page 8 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review, admission and discharge log and interview, the facility failed to maintain a resident record for 1 of 21 sampled residents after discharge (#11) and did not maintain a record of semi-annual [illegible] for 2 of 21 sampled residents (#6 & #30) who required assistance with Activities of Daily Living. Findings: 1. Review of the facility's admission and discharge log revealed resident #11 was not listed. The facility's marketing director was asked to provide several records for review including the record for resident #11, a closed record. On [illegible] at 11 AM, the facility's marketing director said the staff could not locate the record, and she was not a current resident, she said she did not recall the residing in the facility. On [illegible] at 12 PM, staff E, a caregiver who had worked at the facility since [illegible], said she did recall resident #11 residing at the facility in the secured memory care unit. 2. Review of the record for resident #6, admitted [illegible], revealed a health assessment dated [illegible] which documented he required assistance with activities of daily living (ADLs). The record did not find any [illegible] recorded in the facility. 3. Review of the record for resident #30,	A 162		

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A 162	Continued From page 9 admitted [redacted], revealed 2 health assessments, neither of which were signed and dated by the healthcare provider. The assessments documented she required assistance with ADLs. One of the health assessments had a [redacted] documented of 6. The record did not find any [redacted] recorded for 2021 in the facility. Photographic evidence was obtained. On [redacted] at 1:30 PM, the resident care coordinator confirmed the findings and said there were no other [redacted] records available for either resident. Class III	A 162		
A 167 SS=D	59A-36.018 FAC; 429.24 FS Resident Contracts 59A-36.018 Resident Contracts. (1) Pursuant to section 429.24, F.S., the facility must offer a contract for execution by the resident or the resident's legal representative before or at the time of admission. The contract must contain the following provisions: (a) A list of the specific services, supplies and accommodations to be provided by the facility to the resident, including limited nursing and extended congregate care services that the resident elects to receive; (b) The daily, weekly, or monthly rate; (c) A list of any additional services and charges to be provided that are not included in the daily, weekly, or monthly rates, or a reference to a separate fee schedule that must be attached to the contract; (d) A provision stating that at least 30 days written notice will be given before any rate increase; (e) Any rights, duties, or [redacted] of residents,	A 167		

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A 167	Continued From page 10	A 167		

other than those specified in section 429.28, F.S.;
(f) The purpose of any advance payments or deposit payments, and the refund policy for such advance or deposit payments;
(g) A refund policy that must conform to section 429.24(3), F.S.;
(h) A written bed hold policy and provisions for terminating a bed hold agreement if a facility agrees in writing to reserve a bed for a resident who is admitted to a nursing home, health care facility, or [illegible] facility. The resident or responsible party must notify the facility in writing of any change in status that would prevent the resident from returning to the facility. Until such written notice is received, the agreed upon daily, weekly, or monthly rate may be charged by the facility unless the resident's medical condition prevents the resident from giving written notification, such as when a resident is comatose, and the resident does not have a responsible party to act on the resident's behalf;
(i) A provision stating whether the facility is affiliated with any religious organization and, if so, which organization and its relationship to the facility;
(j) A provision that, upon determination by the administrator or health care provider that the resident needs services beyond those that the facility is licensed to provide, the resident or the resident's representative, or agency acting on the resident's behalf, must be notified in writing that the resident must make arrangements for transfer to a care setting that is able to provide services needed by the resident. In the event the resident has no one to represent him or her, the facility must refer the resident to the social service agency for placement. If there is disagreement regarding the appropriateness of placement, provisions outlined in section

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A 167	Continued From page 11 429.26(8), F.S., will take effect; (k) A provision that residents must be assessed upon admission pursuant to subsection 59A-36.006(2), F.A.C., and every 3 years thereafter, or after a significant change, pursuant to subsection (4), of that rule; (l) The facility's policies and procedures for self-administration, assistance with self-administration, and administration of medications, if applicable, pursuant to rule 59A-36.008, F.A.C. This also includes provisions regarding over-the-counter (OTC) products pursuant to subsection (8) of that rule; and, (m) The facility's policies and procedures related to a properly executed DH Form 1896, ... (2) The resident, or the resident's representative, must be provided with a copy of the executed contract. (3) The facility may not levy an additional charge for any supplies, services, or accommodations that the facility has agreed by contract to provide as part of the standard daily, weekly, or monthly rate. The resident or resident's representative must be furnished in advance with an itemized written statement setting forth additional charges for any services, supplies, or accommodations available to residents not covered under the contract. An addendum must be added to the resident contract to reflect the additional services, supplies, or accommodations not provided under the original agreement. Such addendum must be dated and signed by the facility and the resident or resident's legal representative and a copy given to the resident or resident's representative. 429.24 FS (1) The presence of each resident in a facility shall be covered by a contract, executed at the	A 167		

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A 167	Continued From page 12 time of admission or prior thereto, between the licensee and the resident or his or her designee or legal representative. Each party to the contract shall be provided with a duplicate original thereof, and the licensee shall keep on file in the facility all such contracts. The licensee may not destroy or otherwise dispose of any such contract until 5 years after its expiration. (2) Each contract must contain express provisions specifically setting forth the services and accommodations to be provided by the facility; the rates or charges; provision for at least 30 days' written notice of a rate increase; the rights, duties, and [illegible] of the residents, other than those specified in s. 429.28; and other matters that the parties deem appropriate. A new service or accommodation added to, or implemented in, a resident's contract for which the resident was not previously charged does not require a 30-day written notice of a rate increase. Whenever money is deposited or advanced by a resident in a contract as security for performance of the contract agreement or as advance rent for other than the next immediate rental period: (a) Such funds shall be deposited in a banking institution in this state that is located, if possible, in the same community in which the facility is located; shall be kept separate from the funds and property of the facility; may not be represented as part of the assets of the facility on financial statements; and shall be used, or otherwise expended, only for the account of the resident. (b) The licensee shall, within 30 days of receipt of advance rent or a security deposit, notify the resident or residents in writing of the manner in which the licensee is holding the advance rent or security deposit and state the name and address	A 167		

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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
A 167	Continued From page 13	A 167		

of the depository where the moneys are being held. The licensee shall notify residents of the facility's policy on advance deposits.

(3)(a) The contract shall include a refund policy to be implemented at the time of a resident's transfer, discharge, or [illegible]
(b) If a licensee agrees to reserve a bed for a resident who is admitted to a medical facility, including, but not limited to, a nursing home, health care facility, or [illegible] facility, the resident or his or her responsible party shall notify the licensee of any change in status that would prevent the resident from returning to the facility. Until such notice is received, the agreed-upon daily rate may be charged by the licensee.
(c) The purpose of any advance payment and a refund policy for such payment, including any advance payment for housing, meals, or personal services, shall be covered in the contract.

(4) The contract shall state whether or not the facility is affiliated with any religious organization and, if so, which organization and its general responsibility to the facility.

(5) Neither the contract nor any provision thereof relieves any licensee of any requirement or [illegible] imposed upon it by this part or rules adopted under this part.

(6) In lieu of the provisions of this section, facilities certified under chapter 651 shall comply with the requirements of s. 651.055.

(7) Notwithstanding the provisions of this section, facilities which consist of 60 or more apartments may require refund policies and termination notices in accordance with the provisions of part

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	AL11953542	A. BUILDING: _____ B. WING _____	C 09/24/2021

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A 167	Continued From page 14 II of chapter 83, provided that the lease is terminated automatically without financial penalty in the event of a resident's . . . . or relocation due to . , , hospitalization or to medical reasons which necessitate services or care beyond which the facility is licensed to provide. The date of termination in such instances shall be the date the unit is fully vacated. A lease may be substituted for the contract if it meets the disclosure requirements of this section. For the purpose of this section, the term "apartment" means a room or set of rooms with a kitchen or kitchenette and lavatory located within one or more buildings containing other similar or like residential units. This Statute or Rule is not met as evidenced by: Based on resident contract review, facility rate increase letter and interview, the facility failed to provide a 30-day advance notice of a monthly rate increase as required per 59A-36.018(1)(d), Florida Administrative Code. Findings: On at 11:25 AM, resident #6 stated the facility had increased their rates and he was concerned they would make him leave. His rate increased from $1650.00 per month to $3000.00 per month on . . . . . , ... That was an increase of $1350.00 per month. He stated he was only given a 2-week notice. Review of the rate increase letter revealed the letter was signed by the former administrator and was not dated. The letter to resident #6 revealed the same amounts the resident had stated in his interview. Letters for 27 residents were provided. Eleven of the residents who received letters had	A 167		

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A 167	Continued From page 15 already left the facility by . . . Photographic evidence was obtained. On at 2:30 PM, the interim director confirmed that was the letter the residents received, and she was not aware of the requirement to provide at least a 30-day notice of rate increase. Class III	A 167		
CZ813 SS=C	59A-35.090(3)(c), FAC Results of Screening & Notification In File 59A-35.090 Background Screening. (3) Results of Screening and Notification. (c) The eligibility results of employee screening and the signed Attestation referenced in subsection 59A-35.090(2), F.A.C., must be in the employee's personnel file, maintained by the provider. This Statute or Rule is not met as evidenced by: Based on personnel record review, Agency background screening website review, and interview, the facility failed maintain the eligibility results of employee background screening as referenced in subsection 59A-35.090(2), F.A.C., in the personnel file for 1 of 12 sampled staff (I). Findings: Review of the personnel record for the caregiver I revealed a hire date of . No documentation of an eligible level 2 background screen was found in the record. Review of the Agency background screening website on . . . . at 10:30 AM revealed staff I	CZ813		

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CZ813	Continued From page 16 had an eligibility date of [redacted]. On [redacted] at 10:45 AM, the marketing director appointed as interim director confirmed the finding. Unclassified	CZ813		
CZ814 SS=C	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the [redacted] are enrolled in the national retained print [redacted] 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 [redacted] 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; [redacted]; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an	CZ814		

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CZ814	Continued From page 17 individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to maintain the current employment status of all employees within the background screening (BGS) clearinghouse for 4 of 6 sampled staff (Y & AA, BB & CC). Findings: 1. On at 3 PM, the interim assistant executive director said staff Y was on the schedule, but she had started training on . Personnel record review for staff Y revealed a hired date of . Review of the facility's BGS roster on at 10 AM revealed staff Y was not listed as a facility employee. She was eligible as of . 2. On at 2 PM, a letter dated was provided for review. The letter stated the previous administrator was terminated on . Review of the facility's employee roster on the Agency's background screening website on found the former administrator was still listed as a current employee. The interim director also provided letters which documented the termination of caregivers AA, BB, and CC as of . All 3 terminated caregivers were still listed on the employee roster. Photographic evidence was obtained. On at 2:30 PM, the marketing director confirmed the findings. Unclassified	CZ814		

Agency for Health Care Administration

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CZ815 SS=C	408.809(1)( ); 435.02(2); 435.06 FS Background Screening; Prohibited Offenses 408.809 Background screening; prohibited offenses.- (1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are considered employees for the purposes of conducting screening under chapter 435: (a) The licensee, if an individual. (b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider. (c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider. (d) Any person who is a controlling interest. (e) Any person, as required by authorizing statutes, seeking employment with a licensee or provider who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, ␣ with a licensee or provider whose responsibilities require him or her to provide personal care or personal services directly to clients, or ␣ with a licensee or provider to work 20 hours a week or more who will have access to client funds, personal property, or living areas. Evidence of contractor screening may be retained by the contractor's employer or the licensee. (3) All ␣ , must be provided in electronic format. Screening results shall be reviewed by the agency with respect to the offenses specified in s. 435.04 and this section, and the qualifying or disqualifying status of the person named in the	CZ815		

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CZ815	Continued From page 19 request shall be maintained in a database. The qualifying or disqualifying status of the person named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee's behalf. (4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction: (a) Any authorizing statutes, if the offense was a felony. (b) This chapter, if the offense was a felony. (c) Section 409.920, relating to Medicaid provider fraud. (d) Section 409.9201, relating to Medicaid fraud. (e) Section 741.28, relating to domestic violence. (f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection. (g) Section 784.03, relating to battery, if the victim is a adult as defined in s. 415.102 or a patient or resident of a facility licensed under chapter 395, chapter 400, or chapter 429. (h) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems. (i) Section 817.234, relating to false and fraudulent insurance claims. (j) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.	CZ815		

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CZ815	Continued From page 20 (k) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider. (l) Section 817.505, relating to patient brokering. (m) Section 817.568, relating to criminal use of personal identification information. (n) Section 817.60, relating to obtaining a credit card through fraudulent means. (o) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony. (p) Section 831.01, relating to forgery. (q) Section 831.02, relating to uttering forged instruments. (r) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes. (s) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes. (t) Section 831.30, relating to fraud in obtaining medicinal drugs. (u) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony. (v) Section 895.03, relating to racketeering and collection of unlawful debts. (w) Section 896.101, relating to the Florida Money Laundering Act. If, upon rescreening, a person who is currently employed or with a licensee and was screened and qualified under s. 435.04 has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the	CZ815		

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CZ815	Continued From page 21 application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency no later than 30 days after receipt of the rescreening results by the person. (5) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening. (6)(a) As provided in chapter 435, the agency may grant an exemption from disqualification to a person who is subject to this section and who: 1. Does not have an active professional license or certification from the Department of Health; or 2. Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification. (b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may grant an exemption from disqualification to a person who is subject to this section and who has received a professional license or certification from the Department of Health or a regulatory board within that department and that person is providing a service within the scope of his or her licensed or certified practice. (7) The agency and the Department of Health may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, chapter 435, and authorizing statutes requiring background	CZ815		

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CZ815	Continued From page 22 screening and to implement and adopt criteria relating to retaining ◡ , pursuant to s. 943.05(2). (8) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this section, terminates the person against whom the report was issued, whether or not that person has filed for an exemption with the Department of Health or the agency. 435.06 Exclusion from employment.- (1) If an employer or agency has reasonable cause to believe that grounds exist for the denial or termination of employment of any employee as a result of background screening, it shall notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity. (2)(a) An employer may not hire, select, or otherwise allow an employee to have contact with any person that would place the employee in a role that requires background screening until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of employment. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select, or otherwise allow the employee to have contact with any person that would place the employee in a role that requires background	CZ815		

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CZ815	Continued From page 23 screening unless the employee is granted an exemption for the disqualification by the agency as provided under s. 435.07. (b) If an employer becomes aware that an employee has been [illegible] for a disqualifying offense, the employer must remove the employee from contact with any [illegible] person that places the employee in a role that requires background screening until the [illegible] is resolved in a way that the employer determines that the employee is still eligible for employment under this chapter. (c) The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of this chapter or place the employee in a position for which background screening is not required unless the employee is granted an exemption from disqualification pursuant to s. 435.07. (d) An employer may hire an employee to a position that requires background screening before the employee completes the screening process for training and orientation purposes. However, the employee may not have direct contact with [illegible] persons until the screening process is completed and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment. (3) Any employee who refuses to cooperate in such screening or refuses to timely submit the information necessary to complete the screening, including [illegible] if required, must be disqualified for employment in such position or, if employed, must be dismissed. (4) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages against, an employer that, upon notice of a conviction or [illegible] for a	CZ815		

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CZ815	Continued From page 24 disqualifying offense listed under this chapter, terminates the person against whom the report was issued or who was [redacted], regardless of whether or not that person has filed for an exemption pursuant to this chapter. 435.02 Definitions.-For the purposes of this chapter, the term: (2) "Employee" means any person required by law to be screened pursuant to this chapter, including, but not limited to, persons who are contractors, licensees, or volunteers. This Statute or Rule is not met as evidenced by: Based on personnel, facility record review and interview the facility failed to ensure 1 of 12 staff (D) who was in a role that required a background screening did not have any disqualifying offenses and allowed the staff to continue to work without a current screening. Findings: Personnel records review for staff D revealed a hire date of [redacted] and was a caregiver. The review revealed a BGS result dated that indicated he was eligible on [redacted]. The Agency background-screening website on [redacted] at 4 PM revealed staff D required a new screening. On [redacted] at 11 AM, the interim executive director said she had not been made aware. Unclassified	CZ815		
CZ821	59A-35.110 FAC Reporting Requirements; Electronic Submission	CZ821		

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CZ821	Continued From page 25 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections; and, (f) Approval of revisions to emergency management plans. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On	CZ821		

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CZ821	Continued From page 26 Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on	CZ821		

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	AL11953542	A. BUILDING: _____ B. WING _____	C 09/24/2021

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CZ821	Continued From page 27 Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 6. For the purposes of this rule, the following applies for submitting adverse incident reports: a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section	CZ821		

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CZ821	Continued From page 28 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up to $50 per day late not to exceed $500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on facility documentation, resident record review and interview, the facility: 1) failed to report an adverse incident electronically to the Agency as required for 3 of 21 sampled residents (#3, #8 & #16) within 1 business day after the occurrences and 15 calendar days with specific details after the occurrences, and 2) failed to inform the Agency within 10 days of a change in administrator. Findings: 1. On at 9:30 AM, an interview with staff D stated that resident #3 from his shower chair, after being forgotten and left in the shower sometime in was sent out to the hospital and now at a skilled nursing rehabilitation center. Reviewed a facility incident report dated at 1:20 AM, written by staff G,	CZ821		

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CZ821	Continued From page 29 "[Resident #3] found in the bathroom, called hospital then they took him to [name of hospital]." Photographic evidence was obtained. On [redacted] at 2:24 AM, an investigation was conducted by the Depaetment of Children and Families (DCF) and confirmed that staff M left resident #3 sitting on the shower chair, shut the water off and gathered his clothing. Photographic evidence was obtained. Resident #3's record review revealed admission date [redacted]. The health assessment form, dated [redacted], documented medical history of [redacted], and protein-calorie [redacted]. Needs assistance with Activities of Daily Living (ADLs) ambulation, bathing, [redacted], toileting, and transferring. and needs assistance with self-administration of medications. Photographic evidence was obtained. On [redacted] at 1 PM, resident #9, roommate of resident #3, stated that he observed a staff (unknown) went to give resident #3 a shower at around 9 PM. Resident #9 stated that he woke up to resident #3 yelling for help about 12 AM or 1 AM. Resident #9 called 911 for help. On [redacted] at 3:02 PM, another interview with resident #9, and he confirmed that he was the one to call 911 for resident #3 when he [redacted] in the shower on [redacted]. Observation on [redacted] at 3:05 PM in resident #3 and resident #9 bathroom revealed there was no emergency call bell to pull. On [redacted] at 3:10 PM, staff G stated that she	CZ821		

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CZ821	Continued From page 30 worked upstairs in Memory Care unit on second shift PM and worked a double third shift from 11 PM-7 AM downstairs in the 400 wing of Assisted Living residents on the day of this incident. Staff G confirmed that she wrote a quick incident report on at 1:20 AM, after she learned and seen resident #3 on the stretcher being carried out to the hospital by the paramedics while she was assisting resident #4 a few rooms down. Staff G stated that at the time resident #3 could not speak well and was incoherent. When asked staff G who was the staff that put him in the shower earlier and left him, she stated it was staff M. Resident #3's hospital record revealed a date of service on at 1:27 AM. It reflected that resident #3 was admitted for a injury after he rolled his left ankle and in the shower 6 hours ago. It was reflected that resident #3's roommate attempted to call out for help multiple times while resident #3 was on the floor for 6 hours and unable to obtain help from a staff member because there was only 1 caregiver working the facility. 2. On at 11:10 AM, resident #8 was very upset and stated staff K almost tried to kill him by trying to assist giving him triple amount dose of medications at same time of the morning of . Resident #8 stated that he stopped staff K and only took the one dose prescribed because he is aware of what his medications are and how he should take them. On at 11:50 AM, the Resident Care Coordinator confirmed that the incident did happen between staff K and resident #8, and that staff K no longer worked at the facility, terminated on . She stated that the facility wrote an	CZ821		

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CZ821	Continued From page 31 incident report of what happened. At 11:55 AM, the Resident Care Coordinator brought the facility's documentation, dated [redacted] and written by the Interim Assistant Administrator. It confirmed that staff K was terminated on [redacted]. Photographic evidence was obtained. The [redacted] MORs confimed that [redacted], 300 milligrams (mg.), [redacted] 2% [redacted] and [redacted] 25 mg. was listed twice and signed off twice as given. Photographic evidence was obtained. There were no physician orders found in resident #8's record and no facility note for medication clarification found. On [redacted] at 11:25 AM, the Resident Care Coordinator confirmed that she could not locate any physician orders and additional documentation for resident #8. At 12:30 PM, the Interim Administrator confirmed there were no orders found or no additional documentation could be found. On [redacted] at 5:45 PM, the Interim Administrator admitted that no Adverse Incident report was submitted electronically to the Agency for residents #3, #[redacted] #16 and confirmed the findings. 3. Review of resident #16's record revealed a facility admission date of [redacted]. An undated 1823 indicated the resident's diagnoses was [redacted] with [redacted]. Review of a fire department response report that was dated [redacted] revealed documentation that indicated [redacted] was dispatched to the facility for a man who was not eating. They found that resident #16 appeared to be [redacted] and was lying in the [redacted] position on a bed. He was	CZ821		

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CZ821	Continued From page 32 filthy, the room was 90+ degrees, the air conditioner was unplugged, he was wearing pants that were soiled and he was lying on a soiled mattress with no sheets. On the bedside table was a foam cup that contained mold on top of a drink. There was a dresser in the corner of the room with an old sandwich with one bite gone from it sitting on top. The rest of the room was empty. He had a weak and fast radial , . . . Facility stated the resident was last seen normal 3 weeks ago and could not advise when they had checked on him last prior to calling 911. He had a history of being combative but was so weak and frail that he could barely roll over. He smelled of feces and his pants were dry, but stained. He remained responsive to , , and he would localize and be agitated with any touch. Review of a law enforcement report that was dated revealed documentation that on . . . . at approximately 3:56 p.m. an officer was dispatched to the facility. Upon entering resident #16's room, an acrid odor of and feces was smelled. There was dried and feces strewn about the floor. An adult diaper was discarded in a corner of the room behind a dresser. An old, stale, partially eaten sandwich was atop a dresser. A food cart in the room had a cup on it that appeared to contain juice with mold floating on the surface. The bed had no linens or bedspread on it. There was no clothing present in the room. Feces covered the bathroom floor and toilet seat. A police investigator was notified and subsequently responded to the scene. Review of the facility's electronically submitted adverse incident reports revealed none of them were regarding the response of law enforcement and subsequent investigation into the incident involving resident #16.	CZ821		

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CZ821	Continued From page 33 On at 10:56 a.m., staff A said an incident report was not completed and electronically submitted to the Agency, as required. 4. On arrival for the investigation on at 9 AM, the marketing director stated the administrator on record was no longer working in the facility. Request to review the documentation sent to the Agency regarding the change in administrator found there was no documentation available for review. On at 2 PM, a letter dated was provided for review. The letter stated the previous administrator was terminated on . The marketing director appointed as interim director confirmed the finding. Class III	CZ821		
A 000	Initial Comments Complaint Investigations #2020019413, #2021004156, #2021008244, #2021009388, #2021009874, #2021010545, #2021011529, #2021011985, #2021012377, #2021012596, and #2021012885 from through , and . The Palms of Longwood had deficiencies at the time of the visit.	A 000		
A 007 SS=D	59A-36.006(1) FAC Admissions - Criteria (1) ADMISSION CRITERIA. (a) An individual must meet the following minimum criteria in order to be admitted to a facility holding a standard, limited nursing services, or limited mental health license: 1. Be at least	A 007		

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A 007	Continued From page 34 2. Be free from signs and symptoms of any communicable that is likely to be transmitted to other residents or staff. An individual who has ( ) may be admitted to a facility, provided that the individual would otherwise be eligible for admission according to this rule. 3. Be able to perform the activities of daily living, with supervision or assistance if necessary. 4. Be able to transfer, with assistance if necessary. The assistance of more than one person is permitted. 5. Be capable of taking medication, by either self-administration, assistance with self-administration, or administration of medication. a. If the resident needs assistance with self-administration of medication, the facility must inform the resident of the professional qualifications of facility staff who will be providing this assistance. If unlicensed staff will be providing assistance with self-administration of medication, the facility must obtain written informed consent from the resident or the resident's surrogate, guardian, or attorney-in-fact. b. The facility may accept a resident who requires the administration of medication if the facility employs a nurse who will provide this service or the resident, or the resident's legal representative, designee, surrogate, guardian, or attorney-in-fact, contracts with a third party licensed to provide this service to the resident. 6. Not have any special dietary needs that cannot be met by the facility. 7. Not be a danger to self or others as determined by a physician, or mental health practitioner licensed under Chapter 490 or 491, F.S. 8. Not require 24-hour licensed professional	A 007		

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A 007	Continued From page 35 mental health treatment. 9. Not be bedridden. 10. Not have any [illegible] or 4 [illegible]. A resident requiring care of a [illegible], may be admitted provided that: a. The resident either: (I) Resides in a standard or limited nursing services licensed facility and contracts directly with a licensed home health agency or a nurse to provide care; or (II) Resides in a limited nursing services licensed facility and care is provided by the facility pursuant to a plan of care issued by a health care provider; b. The condition is documented in the resident's record and admission and discharge logs; and, c. 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. 11. Residents admitted to standard, limited nursing services, or limited mental health licensed facilities may not require any of the following nursing services: a. [illegible] airway management of any kind, except that of continuous positive airway pressure may be provided through the use of a CPAP or bipap machine; b. Assistance with [illegible], c. Monitoring of [illegible] gases, d. Management of post-surgical drainage tubes and [illegible] vacuum devices; e. The administration of [illegible] products in the facility; or f. Treatment of surgical [illegible] or [illegible], unless the surgical [illegible] or [illegible] and the underlying condition have been stabilized and a plan of care has been developed. The plan of care must be maintained in the resident's record.	A 007		

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A 007	Continued From page 36 12. In addition to the nursing services listed above, residents admitted to facilities holding only standard and/or limited mental health licenses may not require any of the following nursing services: a. , and , , performed in the facility; b. , , performed in the facility. 13. Not require 24-hour nursing supervision. 14. Not require skilled rehabilitative services as described in Rule 59G-4.290, F.A.C. 15. Be appropriate for admission to the facility as determined by the facility administrator. The administrator must base the determination on: a. An assessment of the strengths, needs, and preferences of the individual; b. The medical examination report required by Section 429.26, F.S., and subsection (2) of this rule, if available; c. The facility's admission policy and the services the facility is prepared to provide or arrange in order to meet resident needs. Such services may not exceed the scope of the facility's license unless specified elsewhere in this rule; and, d. The ability of the facility to meet the uniform fire safety standards for assisted living facilities established in rule Chapter 69A-40, F.A.C. (b) A resident who otherwise meets the admission criteria for residency in a standard licensed facility, but who requires assistance with the administration and regulation of portable or assistance with routine care of site placement, may be admitted to a facility with a standard license as long as the facility has a nurse on staff or under contract to provide the assistance or to provide training to the resident on how to perform these functions themselves. (c) Nursing staff may not provide training to	A 007		

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A 007	Continued From page 37 unlicensed persons, as defined in Section 429.256(1)(b), F.S., to perform skilled nursing services, and may not delegate the nursing services described in this section to certified nursing assistants or unlicensed persons. This provision does not restrict a resident or a resident's representative from . . . . . with a licensed third party to provide the assistance if the facility is agreeable to such an arrangement and the resident otherwise meets the criteria for admission and continued residency in a facility with a standard license. (d) An individual enrolled in and receiving hospice services may be admitted to an assisted living facility as long as the individual otherwise meets resident admission criteria. (e) Resident admission 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 record reviews and interview, the facility failed to have documentation to indicate 2 of 21 sampled residents met the minimum criteria for admission to an assisted living facility (ALF) (#16 & #30). Findings: 1. Resident #16's record contained only one 1823 assessment form that was undated, and the questions as to whether the resident posed a danger to self or others and whether the resident required 24-hour nursing or , , care were not answered. The form indicated the resident's diagnoses were . . with , , . . . The record did not contain documentation to indicate the facility contacted a health care provider to obtain the omitted information to aid the facility in determining whether the resident met the	A 007		

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A 007	Continued From page 38 minimum criteria for admission to the facility. On [redacted] at 2:30 p.m., staff C confirmed the findings and was unable to provide additional documentation. 2. Resident #30 revealed an admission date of [redacted]. The most recent, undated health assessment documented diagnoses including [redacted], and [redacted]. The undated health assessment reflected that the resident's needs could not be met in an assisted living facility. The resident's record did not contain documentation to indicate the facility contacted a health care provider to obtain a clarification of information to determine if the resident met the minimum criteria for admission to the facility. Photographic evidence was obtained. On [redacted] at 12:10 PM, the resident care coordinator confirmed the finding. Class III	A 007		
A 008 SS=D	429.26( ) FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner,	A 008		

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A 008	Continued From page 39 must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner's direct observation of the patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form, reflecting the resident's condition on the date the examination is performed, becomes a permanent part of the facility's record of the resident and must be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and	A 008		

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A 008	Continued From page 40 Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or , , nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of , , , , , , , , , , , , , , require such assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a . . . .-to- . . . medical examination completed by a health care provider as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 calendar days before the individual's admission to a facility pursuant to Section 429.26(4), F.S. The examination must address the following:	A 008		

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A 008	Continued From page 41 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations, 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living, 3. Any nursing or [illegible] services required by the individual, 4. Any special diet required by the individual, 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication, 6. Whether the individual has signs or symptoms of [illegible] or any other communicable [illegible], which are likely to be transmitted to other residents or staff, 7. A statement on the day of the examination that, in the opinion of the examining health care provider, the individual's needs can be met in an assisted living facility; and, 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care provider. The medical examination may be conducted by a health care provider licensed under Chapter 458, 459 or 464, F.S. (b) A medical examination completed after the resident's admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, [illegible], which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09170. Faxed or electronic copies of the completed form are acceptable. The form must be completed as instructed. 1. Items on the form that have been omitted by	A 008		

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A 008	Continued From page 42	A 008		

the health care provider during the examination may be obtained by the facility either orally or in writing from the health care provider.
2. Omitted information must be documented in the resident's record. Information received orally must include the name of the health care provider, the name of the facility staff recording the information, and the date the information was provided.
3. Electronic documentation may be used in place of completing the section on AHCA Form 1823 referencing Services Offered or Arranged by the Facility for the Resident. The electronic documentation must include all of the elements described in this section of AHCA Form 1823.
(c) Any information required by paragraph (a), that is not contained in the medical examination report conducted before the individual's admission to the facility must be obtained by the administrator using AHCA Form 1823 within 30 days after admission.
(d) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b).
(e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.26, F.S. and this rule.
(f) Any orders issued by the health care provider conducting the medical examination for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility may be attached to the health assessment. A health care provider may attach a

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A 008	Continued From page 43 DH Form 1896, Florida . . . . . Form, for residents who do not wish . . . . . to be administered in the case of or . . . . . (g) 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 the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on resident record review and interview, the facility failed to ensure the health assessment was complete and accurate for 5 of 21 sampled records (#4, #10, #13, #16 & #30). Findings: 1. Resident #30's record revealed an admission date of . . . . . The most recent health assessment listed diagnoses including . . . . . , and , ... The undated health assessment reflected the resident's needs could not be met in an assisted living facility. Pages 4 and 5 were missing. Photographic evidence was obtained. On at 12:10PM, the resident care	A 008		

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A 008	Continued From page 44 coordinator confirmed the finding. 2. Resident #4's 1823 assessment form, dated , revealed the examiner's address and phone number were not provided, and page five of the form was incomplete. 3. Resident #16's undated 1823 assessment revealed the facility information was incomplete. The resident's and were not documented, the questions as to whether or not the resident posed a danger to self or others, and whether 24-hour nursing or care was required were not answered, whether the resident required help with taking medications was not answered. The address and phone number of the examiner were not provided, and page five of the form was incomplete. Both resident #4 and #16's records did not contain documentation to indicate the facility contacted a health care provider to obtain the omitted information. On at 2:30 p.m., staff C confirmed all of the findings and was unable to provide additional documentation. 4. Health assessment report dated for resident #13 listed diagnoses of moderate , high and . According to the report, she had moderate forgetfulness and needed someone to administer her medications. The and medication observation records indicated she received assistance with self-administration of medications from the facility's unlicensed staff. On at 11 AM, the Resident Care	A 008		

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A 008	Continued From page 45 Coordinator said she did not have a revised health assessment or an order that indicated the resident could receive assistance with self -administration of medications, becasuse she was able to assist. 5. Resident #10's record revealed he was admitted to the facility on . The resident's health assessment form 1823 revealed page 4 and page 5 was missing. Page 4 was where the health care provider would include information and the date the assessment was completed, and the medication list and the type of assistance he required with his medication. On at 3 PM, the marketing director who was in charge confirmed the findings. Class III	A 008		
A 028 SS=D	59A-36.007(4) FAC Resident Care - Activities of Daily Living (4) ACTIVITIES OF DAILY LIVING. Facilities must offer supervision of or assistance with activities of daily living as needed by each resident. Residents should be encouraged to be as independent as possible in performing activities of daily living. This Statute or Rule is not met as evidenced by: Based on review of the facility's shower list and interview, the facility failed to provide showers as scheduled for 3 of 3 sampled residents (#4, #9 & #34). Findings: 1. Review of the facility's shower schedule revealed resident #9 was to receive showers on	A 028		

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A 028	Continued From page 46 Mondays and Thursdays from the 3 PM-11 PM staff. On at 9:45 AM, resident #9 said he was to receive showers on Monday's and Thursdays. He said he did not receive a shower last week at all. It was the Thursday prior to last week. He said the staff did not have time to give him a shower, and he was unable to take a shower without assistance from the staff. On at 10:30 AM, staff E, a caregiver who provided assistance with medication, said she worked 7 AM-3 PM and 3 PM-11 PM on , and they did give resident #9 his shower today, . She said he did not get one yesterday because she did not have time to give it. He requires 2 person assist with showers and sometimes there is not enough staff available to provide showers. 2. Resident #34 was to receive a shower on Monday and Thursdays from the 7 AM-3 PM staff. On at 10: 15 AM resident #34 said he received assistance with showers, and he did not recall getting a shower on as he was supposed to. On at 10:30 AM, Staff E, a caregiver who provided assistance with medication who said she worked 7 AM-3 PM and 3 PM-11 PM on , She confirmed resident #34 did not receive a shower because they did not have time to get to him. On at 10:45 AM, staff V, a caregiver, said she worked 7 AM-3 PM and 3 PM -11 PM on . She said she was not able to give	A 028		

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A 028	Continued From page 47 showers to every resident because they had other things to do because they were short staff. She said they had to do dining also and give medications. She said she was not able to give a shower to residents #9 and #34 because the staff did not have time to. She said resident #9 required 2 person assist and resident #34 required a 3 person assist. She said they tried to do what they could. On .. . . . . at 3 PM, the marketing director who was in charge was not aware the residents were not getting their showers as required. 3. Review of resident #4's 1823 assessment form, dated , revealed documentation that indicated the resident required assistance by staff with bathing. Review of the facility's shower schedule revealed resident #4 was scheduled to receive a shower on . On at 10:08 a.m., resident #4 said she did not receive a shower on .. . . . and said staff Q told her on that she could not give the resident a shower because the facility was short staffed but that she would try to give the resident one on . . . . . however, the resident said she did not receive one on that date either. On at 10:34 a.m., staff Q said she did not assist resident #4 with a shower on either .. . .. or because the facility was short staffed and too busy. Class III	A 028		

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A 030	Continued From page 48	A 030		
A 030 SS=D	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) 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, 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	A 030		

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A 030	Continued From page 49 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 standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (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 telephone on each floor of each building where residents reside. 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	A 030		

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A 030	Continued From page 50 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 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	A 030		

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A 030	Continued From page 51 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 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.	A 030		

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A 030	Continued From page 52 (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 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.	A 030		

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PALMS OF LONGWOOD (THE)	480 EAST CHURCH AVENUE LONGWOOD, FL 32750

(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 030	Continued From page 53 429.27 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 facility documentation, resident record review and interview, the facility failed to establish a grievance policy and procedure; and the facility failed to respond to grievances for 2 of 21 sampled residents honoring resident rights as required (#7 & #15). Findings: Facility documentation was reviewed. There was no evidence of a grievance policy and procedures established. On at 1:15 PM, and at 9:52 AM, the grievance policy was requested from the Resident Care Coordinator but did not provide the policy.	A 030		

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A 030	Continued From page 54 On .. .. at 12:30 PM, the Interim Administrator was asked to provide the facility's grievance log and policies of how grievances are handled when received. The Interim Administrator confirmed that she could not locate the policy, and she was not aware that grievances should be logged in and tracked for response. 1. Resident #7's record revealed an admission date on . On , a written grievance was submitted to the previous administrator by the resident's daughter for never being notified that her mother had COVID-19 until ,when she was informed by the hospital due to her mother being transported to the hospital for fainting one week later. On at 11:55 AM, an interview with the daughter revealed she wanted to know why the facility did not notify her of her mother's change in condition. The resident's daughter was visiting her mother and packing up some of her items, preparing for her mother to move on .. .. to a facility closer to her home. 2. Resident #15's record revealed an admission date on .. .. On .. .. , a verbal grievance was submitted to the Interim Administrator by the resident's daughter stating that communication stopped on from the facility after she was notified via text message that her mother was positive for COVID-19 on .. .. On .. .. at 12:53 PM via telephone, the resident's daughter stated that she continuously had to call the facility on .. .. to follow up with her mother's health change, and no one ever answered the facility telephone, and did not return a call after leaving a voicemail message.	A 030		

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A 030	Continued From page 55 The daughter stated that she had visited her mother on at 9 AM, and had to wait outside the gates for 30 minutes before entering. After the daughter entered the facility, she asked staff K, who answered the gate, why it took so long to let her in. Staff K stated the facility was short staffed. The daughter then said she found her mother in soiled clothing near the outside front patio. She took her mother to her room to change her and saw no sheets on a soiled mattress on both sides. She stated the facility was not taking care of her mother with dignity, and she was very upset about it. The resident was moved from the facility on . On at 5:45 PM, the Interim Administrator admitted that she did not respond to the grievances and she confirmed the above findings. Class III	A 030		
A 033 SS=D	59A-36.007(8) PHYSICAL . . (8) PHYSICAL . Residents for whom a physician has prescribed a physical must have a written care plan for the use of the physical . The care plan must be developed within 14 days of the device being prescribed, and prior to use on the resident. (a) The care plan must specify: 1. The device prescribed for use; 2. The maximum amount of time the resident is to have the applied each day; and, 3. In what manner and frequency staff will monitor, observe, and report to the physician any injuries, increase in agitation, signs and symptoms of , , or decline in mobility or function related to the use of the prescribed	A 033		

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A 033	Continued From page 56 . . . . . . (b) Facility staff must ensure that the device is applied appropriately and safely. (c) The resident's physician must review the appropriateness of the continued use of the physical annually, and documentation of this review must be maintained in the resident's record. If the resident's ability to independently remove or avoid the device fluctuates, the device must be considered a physical and all requirements of this subsection apply. This Statute or Rule is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure the use of physical were care planned, and the order reviewed by the physician yearly for 1 of 21 sampled residents (#1). Findings: Observations on at 10:15 AM noted the bed on resident #1 had half-bed rails in place. Resident #1's record health assessment, dated , listed diagnoses of advanced 's , , type II and slow cognition. The order, dated , indicated half- bed rail for mobility and repositioning. The recoed did not contain any evidence that the order was reviewed yearly thereafter. There was no evidence of a care plan that indicated the type of device prescribed, the maximum amount of time the resident had the applied each day, and the manner and frequency staff would monitor, observe, and report to the physician any injuries, increase in agitation, signs, and symptoms of , , or decline in mobility or function related to the use of the prescribed .	A 033		

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A 033	Continued From page 57 On at 11 AM, the Resident Care Coordinator said she did not have any additional documentation regarding the half-bed rails. Class III	A 033		
A 036 SS=D	59A-36.007(10) CONTROL PROCEDURES (10) CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of (a) The facility must implement a hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or hygiene may include the use of -based rubs, handwash, or handwashing with soap and water. (b) Standard precautions must be used when there is an exposure to transmissible agents in , nonintact skin, and mucuous during the provision of personal services. Standard precautions include: hygiene, and dependent upon the exposure, use of gloves, gown, mask, protection, or a shield. (c) The facility must clean and reusable medical equipment and communal assistive devices that have been designed for use by multiple residents before and after each use according to the manufacturer's recommendations. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and	A 036		

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A 036	Continued From page 58 interview, the facility failed to provide services in a manner that reduced the risk of transmission of [illegible] when 1 of 2 sampled staff (D) who assisted 2 of 4 sampled residents with checking a [illegible] level failed to wear gloves (#4 & #29). Findings: 1. On [illegible] at 11:23 a.m., staff D was performing a [illegible] monitoring on resident #4. The staff member first used [illegible] sanitizer, then removed [illegible] supplies from a medication cart. He then took the supplies to the resident's bedside. He prepped the resident's [illegible] with [illegible], stuck the [illegible] with a lancet, then applied [illegible] to the test strip. The staff member did not put on gloves prior to performing the task and did not sanitize or wash his [illegible] afterwards. 2. On [illegible] at 11:29 a.m., staff D left resident #4's room and pushed the medication cart to resident #29's room. The resident came to the door and stuck his [illegible] out. The staff member removed [illegible] supplies from the cart then prepped the resident's [illegible] with [illegible]. He then stuck the [illegible] with a lancet and placed a drop of [illegible] on a test strip. The staff member did not sanitize or wash his [illegible] and did not apply gloves prior to performing the task. On [illegible] at 10:40 a.m., the findings were discussed with staff D, who confirmed them and said he should have worn gloves and performed [illegible] hygiene. Review of the facility's undated [illegible] control policy and procedures revealed that employees should wash their [illegible] before and after	A 036		

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A 036	Continued From page 59 assisting with a task that may involve contact with , and must wash before and after providing assistance with self-administration of medication to each resident. Class III	A 036		
A 053 SS=G	59A-36.008(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION. (a) For facilities that provide medication administration, a staff member licensed to administer medications must be available to administer medications in accordance with a health care provider's order or prescription label. (b) Unusual reactions to the medication or a significant change in the resident's health or behavior that may be caused by the medication must be documented in the resident's record and reported immediately to the resident's health care provider. The contact with the health care provider must also be documented in the resident's record. (c) Medication administration includes conducting any examination or other procedure necessary for the proper administration of medication that the resident cannot conduct personally and that can be performed by licensed staff. (d) A facility that performs clinical laboratory tests for residents, including testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Chapter 483, Part I, F.S. A valid copy of the federal CLIA Certificate must be maintained in the facility. A federal CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a federal CLIA Certificate if	A 053		

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A 053	Continued From page 60 facility staff assist residents in performing clinical laboratory testing with the residents' equipment. Information about the federal CLIA Certificate is available from the Laboratory and In-Home Services Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)412-4500. This Statute or Rule is not met as evidenced by: Based on the electronic medication observation record, record review and interviews, the facility did not ensure a nurse was available to administer as ordered by the health care provider and to obtain testings for 1 of 21 sampled residents (#10). Findings: Resident #10's medication observation record (MOR) for , , listed Solor star 100 unit/milliliter (ml.) give 25 units every evening. The MOR contained the initials of unlicensed staff as giving the medication at 4 PM. The label on the , read, "inject 25 units every night at bedtime." An order, dated , read " units/100 ml. solution, 25 units at bedtime." On at 3:30 PM, staff D, an unlicensed caregiver, took resident #10's level and documented it on a piece of paper that was personally his. The result was 421. He then placed the needle on the , and instructed the resident how to use the , . Staff D had to tell the resident to press the pen down on his to inject the . Staff D said resident #10 was not capable of doing his	A 053		

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A 053	Continued From page 61	A 053		

own without assistance. Staff D said he would take the resident's before providing the , and there were no orders for it. He said he would do it on his own. He said the resident's were high because he would drink a lot of soda. Staff D said at one time there use to be nurses to provide to the residents and conduct checks, but the previous administrator said that the unlicensed staff could now do the and . He further stated he would assist with the at 3:30-4 PM instead of bedtime as ordered, because the previous administrator instructed the staff not to give the at bedtime because there would not be anyone there to do it.

A physician's order, dated , reflected to monitor 3 times before meals and regular , and continue 20 units daily. Further record review revealed there was no documentation that the resident's was obtained 3 times daily and that the resident received the regular . There was no documentation that the facility staff had checked with the health care provider to get clarification of the orders for .

A telephone interview was conducted with the marketing director who was in charge of the facility on at 1:30 PM. She said resident #10's health care provider was at the facility on and confirmed that the resident was required to have with a 3 times a day as the order dated noted. She said the health care provider administered the resident's while he was there, she said the resident had not received any more of the per the sliding

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A 053	Continued From page 62 scale since . . . . . because there was no nurse there to provide it to the resident who could not do it himself. Class II	A 053		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known . . . . the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical . . . , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the	A 054		

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A 054	Continued From page 63 medication. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the Medication Observation Record (MOR) for 2 of 21 sampled residents was properly updated (#1 & #4), and failed to ensure the MOR for 1 of 21 sampled residents was accurate (#8). Findings: 1. Resident #4's 1823 assessment form, dated , indicated the resident required assistance with self-administration of medications. The resident's , MOR revealed an entry for inject 20 units , every day scheduled for 7 a.m. Staff D circled the dose on , , , and , and documentation on the MOR indicated the medication was held due to a change in direction. On at 10:40 a.m., staff D said he did not give resident #4 the on the dates he circled because there was an order to give it at 9 p.m. and said there should have been an order in the resident's record. Review of the prescription label revealed the instructions were to give the daily and did not specify a time. On at 10:50 a.m., resident #4 said she did receive her every night this month. On at 3:20 p.m., staff W said he gave resident #4 the at 7 p.m. on ,	A 054		

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A 054	Continued From page 64	A 054		

. . . , . . . , . . . and . . . . . . He said he did not document anywhere when he injected it, and said he knew it had to be given at that time because the resident told him to.

2. Resident #1's health assessment, dated . . . . . , listed advanced . . . . . 's . . . . . , type 2 , and slow cognition. According to the assessment, he needed assistance with self-administration of medications.

The , MOR listed:
. . . . . 20 units daily had a letter "X " from to , staff initials circled on . . . . , . . . and . . . . . , and indicated change in direction. There were no explanations as to what the "X" meant.
take 30 units every morning and 25 units in the evening was listed at 7 AM had a letter "X" from to , , and . . . . . was indicated as "change in direction".
. . . . . 25 milligrams (mg.) daily had a letter "X" on . . . . . There were no explanations as to what was the meaning of "X" or what was the "change in direction".
. . . 500 mg. twice daily at 7 AM and 7 PM was blank from to at 7 AM.
, ... powder to the affected area twice daily at 7 AM and 7 PM was blank from to at 7 AM.
test strip use every morning "nurse only" was marked as done . . . . , ... and from to , however, the results were not documented on the MOR.
The 7 AM medications on were marked as "admitted to hospital". The resident had a . at 5:15 AM and returned to the facility at approximately 11 AM.

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A 054	Continued From page 65 The [illegible] MOR indicated: [illegible] test strip use every morning "nurse only" was marked as done every day at 8 AM, however, the actual results were not listed but staff initials were documented. The medication notes in the MOR indicated on [illegible] at 3 PM, the resident was admitted to the hospital and the notes continued to indicate "hospitalized" on [illegible] at 4 PM. On [illegible] at 7 PM and 8 PM, the MOR indicated "resident moved out". On [illegible] and [illegible] D 1.25 mg. was marked as "completed order". On [illegible] at 7 AM, 11 AM, 3 PM, 4 PM, 7 PM and 8 PM, notes read "resident was hospitalized" yet on [illegible] at 8 AM, it indicated that [illegible] was held per nurse practitioner order for low [illegible] test strip use to test [illegible] as needed "nurse only" and was blank from [illegible] to [illegible]. The [illegible] MOR indicated: [illegible] at 8 AM [illegible] was held "[illegible] was low"; result was not indicated. [illegible] at 8 AM [illegible] not given [illegible] low, result was not indicated. [illegible] and [illegible], the MOR was blank at 4 PM. There were no written notations as to why. [illegible] test strip use every morning "nurse only" was marked as done every day at 8 AM, however, the actual results were not listed but staff initials were documented. On [illegible] at 12:50 PM, the resident care director said the resident went to the emergency room, came [illegible], and went [illegible] to the emergency room and was hospitalized. He and had a [illegible] on [illegible], but no [illegible]. The medication technicians thought that the	A 054		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALMS OF LONGWOOD (THE)	480 EAST CHURCH AVENUE LONGWOOD, FL 32750

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 054	Continued From page 66 was discontinued. 3. Resident #8's record review revealed admission date of . The 1823 Health Assessment form, dated , listed medical conditions of , type 2 no but oral medication, Defibrillator and Activity of Daily Living (ADLs) with independent in all. He required assistance with self-administration of medications. Photographic evidence was obtained. On at 11:10 AM, resident #8 was very upset and said staff K almost tried to kill him by trying to assist giving him triple amount dose of medications at same time of the morning of . Resident #8 stated that he stopped staff K and only took the one dose prescribed because he is aware of what his medications are and how he should take them. On at 1 PM, the Resident Care Coordinator provided resident #8's MORs for , and . The , Medication Observation Record (MORs) listed twice and signed off twice as given as follows: , 300 mg. two capsules by every 8 hours at 7 AM, 2 PM and 10PM and listed again , 300 mg. two capsules by every 8 hours at 6 AM, 2 PM and 10 PM. , 2% , three times daily at 7 AM, 2 PM and 10 PM, and listed again , 2% , three times daily at 6 AM, 2 PM and 10 PM. , 25 mg. tablet by (12.5 mg.) daily at 7AM, and listed again , 25 mg. 1 whole tablet by	A 054		

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A 054	Continued From page 67 once daily at 7 AM. Photographic evidence was obtained. There were no physician orders found in resident #8's record and no facility note for clarification of the medication oders found on the MORs. On at 9:52 AM, the Resident Care Coordinator was asked to provide physician orders for the three medications found on , MORs duplicated and any facility documentation they had. At 10:55 AM, the Interim Assistant Administrator was also asked for the physician orders of the three medications found on , MORs duplicated and any facility documentation. At 11:25 AM, the Resident Care Coordinator confirmed that she could not locate any physician orders and additional documentation for resident #8's medications. On at 5:45 PM, an interview with the Interim Administrator confirmed the findings. Class III	A 054		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out	A 055		

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A 055	Continued From page 68 of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to	A 055		

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A 055	Continued From page 69 the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observations, records review and interview, the facility failed to ensure: 1. Medication that was discontinued, but not	A 055		

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A 055	Continued From page 70 expired, was returned to the resident. 2. That centrally stored discontinued medications were stored separately from medication in current use, and the area in which it was stored must be marked "discontinued medication." 3. When a resident's stay in the facility has ended, the administrator returned all medications to the resident, unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed. 4. Medications that have been abandoned/expired were disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record for 2 of 35 sampled residents (#33 & #35). Findings: On [redacted] at 11;40 AM, staff D said the discontinued medications were kept in a cabinet at the front office. A 2-drawer cabinet was observed. Both drawers was were not labeled "discontinued medication". Further observation noted a large quantity of medications in both drawers. Staff D said the top drawer was "overflow medications" and the bottom drawer were discontinued medications for past and present residents. He added that there were 2 bubble packs of medications that belonged to resident #33, who had moved out of the facility some time ago. Observations of the second drawer noted multiple medications that belonged to multiple residents. Staff D said some of the medications belong to residents who either [redacted] or moved out long ago. He added there was a system in place to verify	A 055		

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A 055	Continued From page 71 that residents or families were notified about the medications still left at the facility. The medications simply were kept in the drawer and eventually discarded. Observation of the refrigerated medications revealed a clear plastic bag with 2 Balgasar dial pens with prescription label dated that indicated Balgasar inject 10 units every night at bedtime for resident #12, who was discharged from the facility. Another clear plastic bag had contained a dial pen a prescription label and indicated . . . inject 20 units every evening at 9 PM for former resident #35. On at 11 :15 AM, the interim executive director offered no comment and confirmed the findings. Class III	A 055		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill	A 056		

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A 056	Continued From page 72 organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort	A 056		

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A 056	Continued From page 73 to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observations and interview, the facility failed to ensure not to store prescription drugs for self-administration, assistance with self-administration, or administration unless they were properly labeled and dispensed in accordance with Chapters 465 and 499, Florida Statute, and 64B16-28.108, Florida Administrative Code.	A 056		

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A 056	Continued From page 74 Findings: On [illegible] at 11:40 AM, staff D said the discontinued medications were kept in a cabinet at the front office. Observations noted a 2-drawer cabinet, neither drawer was labeled "discontinued medication". Further observation noted a large quantity of medications in both drawers. Staff D said the top drawer was "overflow medications" and the bottom drawer discontinued medications for past and present residents. There was a clear plastic bag full of prefilled syringe that was not labeled. Staff D said the medication was [illegible] that belonged to a resident who had [illegible]. Observation of the refrigerated medications noted a [illegible] that was not labeled. On [illegible] at 11:15 AM, the interim executive director offered no comment and confirmed the findings. Class III	A 056		
A 077 SS=G	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who	A 077		

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A 077	Continued From page 75 has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least [illegible]; 2. If employed on or after [illegible], have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator.	A 077		

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A 077	Continued From page 76 Administrators who attended core training prior to , , , are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must	A 077		

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A 077	Continued From page 77 satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , ... , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the administrator who was responsible for operation of the facility failed to ensure: 1. the Agency was contacted within 10 days of a change in administrator, 2. failed to ensure a nurse was available to administer . . , and did not ensure all staff providing services to residents were qualified to perform those duties in accordance with their level of training & education, and allowed unlicensed staff to administer medications to residents who were unable to self-administer , 3. resident physicians were allowed access to	A 077		

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A 077	Continued From page 78 their patient's facility records, 4. resident medications were provided to residents according to physician orders, were documented accurately and were properly labeled and stored, 5. staffing levels met minimum requirements and were sufficient to meet the needs of the residents for assistance with activities of daily living, 6. the facility . . . . control policy was followed, and services were provided in a manner that reduced the risk of transmission of . . . . . , 7. all residents met admission requirements and criteria for continued residency, 8. the facility was safe, home-like, and decent environment which was free from black and brown substances on the ceiling and air conditioning vents, stains on the walls, and stained and dirty carpets throughout the facility, 9. residents were provided the required 30-day advance notice for a rate increase, 10. a complete and accurate admission-discharge log of all residents in the facility was maintained, 11. staff and resident records were retained following discharge as required. Findings: During the investigation of multiple complaint investigations from . . . . through . . . . , the following evidence was found that indicated the residents were not fully supported and protected by the administration: 1. On arrival for the investigation on at 9 AM, the marketing director appointed as interim director as of , stated the administrator on record (staff L) no longer worked in the facility. Request to review the documentation sent to the	A 077		

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A 077	Continued From page 79 Agency regarding the change in administrator found there was no documentation available for review. On at 2 PM, a letter dated was provided for review. The letter stated the previous administrator was terminated on . 2. On at 3:30 PM, staff D, an unlicensed caregiver, was observed taking the resident's level and documented it on a paper that was personally his, the result was 421. He then placed the needle on the and instructed resident #10 on how to use it and said resident #10 was not capable of doing his own without assistance. Staff D said at one time there use to be nurses to provide to the residents and conduct check and the previous administrator said that the unlicensed staff could now do the and . He further stated he would assist with the at 3:30-4 PM instead of bedtime as ordered, because the previous administrator instructed the staff not to give the at bedtime because there would not be anyone there to do it. A telephone interview was conducted with the interim director on at 1:30 PM, she said resident #10's health care provider was at the facility on and confirmed that the resident was required to have with a 3 times a day as the order dated noted. She said the health care provider administered the resident's while he was there, she said the resident had not received any more of the per the since because there was no nurse there to provide it to the resident who could not do it himself.	A 077		

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PALMS OF LONGWOOD (THE)	480 EAST CHURCH AVENUE LONGWOOD, FL 32750

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A 077	Continued From page 80	A 077		

3. On [redacted] at 9:45 AM, a telephone call was made to the health care provider for resident #10. He said he no longer provided care to the residents of the facility because the previous administrator would not allow him to do what he needed to do for the residents and refused to allow him to review the resident's medication and told him it was a HIPPA violation even though he was the resident's doctor. He said he gave a 30-day notice to his patients there because of the multiple problems at the facility.

4. Review of the [redacted] MOR for resident #4 revealed an entry for [redacted] inject 20 units [redacted], every day that was scheduled for 7 a.m. Staff D circled the dose on [redacted] and [redacted], and documentation on the MOR indicated the medication was held due to a change in direction.

On [redacted] at 10:40 a.m., staff D said he did not give resident #4 the [redacted] on the dates he circled because there was an order to give it at 9 p.m. and said there should have been an order in the resident's record. Review of the prescription label revealed the instructions were to give the [redacted] daily and did not specify a time. On [redacted] at 3:20 p.m., staff W said he gave resident #4 the [redacted] at 7 p.m. on [redacted] and [redacted]. He said he did not document anywhere when he gave it and said he knew it had to be given at that time because the resident told him to.

Review of the [redacted] MOR for resident #1 revealed the following: [redacted] 20 units once daily was marked with an "X" from [redacted] to [redacted], staff initials circled on [redacted], and [redacted] and indicated change in direction. [redacted] take 30 units every

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A 077	Continued From page 81	A 077		

morning and 25 units in the evening was listed at 7 AM and marked with "X" from to , and was indicated as "change in direction". 25 mg. daily and marked with "X" on . There were no explanations as to what was the meaning of "X" or what was the change in direction. 500 mg twice daily at 7 AM and 7 PM was blank from to at 7 AM. powder to affected area twice daily at 7 AM and 7 PM was blank from to at 7 AM. test strips use every morning "nurse only" were marked as done , and from to , however the results were not documented on the MOR.

On at 11:10 AM, resident #8 was very upset and said staff K almost tried to kill him by trying to assist giving him triple amount dose of medications at same time of the morning of . Resident #8 stated that he stopped staff K and only took the one dose prescribed because he is aware of what his medications are and how he should take them.

Review of the MOR found medications listed twice and signed off twice as given as follows: 300 milligrams (mg.) two capsules by every 8 hours at 7 AM, 2 PM and 10 PM and listed again , 300 mg. two capsules by every 8 hours at 6 AM, 2 PM and 10 PM. , 2% to apply , three times daily at 7 AM, 2 PM and 10 PM and listed again , 2% to apply , three times daily at 6 AM, 2 PM and 10 PM. , 25 mg. to be taken tablet by (12.5 mg.) daily at 7AM and listed again , 25 mg. to be taken 1 whole tablet by once daily at 7AM. No physician orders were found in resident #8's

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A 077	Continued From page 82 record and no notes were found that the facility attempted to obtain clarification from the resident's physician for the orders were found. 5. Staff schedules and time sheets were reviewed for the week of , , 2021. Staff hours required were 498 for the reported 83 residents that week. Review of the time sheets provided showed the facility had a total of 442.5 staff hours from /2021, which does not meet the minimum staffing requirement. Staff hours for the week of were reviewed. Staff hours required were 416 for the reported 58 residents that week. The staff scheduled showed 468 hours were scheduled, but sampled residents #4, #9 & #34 complained they were not getting showers due to not enough staff available. On at 10:34 a.m., staff Q said she did not assist resident #4 with a shower on either or because the facility was short staffed and too busy. On at 10:30 AM, Staff E, caregiver who provided assistance with medication said on who said they did give resident #9 his shower today. She said he did not get one yesterday because she did not have time to give it. He requires 2 person assist with showers and sometimes there is not enough staff available to provide showers. 6. On at 11:23 a.m., staff D was observed performing a monitoring on residents #4 & #29. The staff member first used sanitizer then removed supplies from a medication cart. He then took the supplies to the resident's bedside. He prepped the resident's with , stuck the with a lancet, then applied to the test strip. The staff member did not put on gloves prior to performing the task nor did he sanitize or wash his afterwards.	A 077		

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A 077	Continued From page 83 Staff D left resident #4's room and pushed the med cart to resident #29's room. The resident came to the door and stuck his ⌄ . out. The staff member removed supplies from the cart then prepped the resident's ⌄ with . He then stuck the ⌄ with a lancet and placed a drop of . . . . on a test strip. The staff member did not sanitize or wash his and did not apply gloves prior to performing the task. On at 10:40 a.m. the findings were discussed with staff D, who confirmed them and said he should have worn gloves and performed . . hygiene. 7. Review of resident #16's record revealed it contained only one undated health assessment and the questions as to whether or not the resident posed a danger to self or others and whether or not the resident required 24-hour nursing or , ⌄ care were not answered. The form indicated the resident's diagnoses was with ⌄ . Resident #30's record revealed an admission date of . . . . . The most recent, but undated, health assessment documented the resident's needs could not be met in an assisted living facility. The resident's record did not contain documentation to indicate the facility contacted a health care provider to obtain a clarification of information to determine if the resident met the minimum criteria for admission to the facility. 8. Observation on revealed there were brown ceiling stains next to . . . . , further observations revealed there was also black speckled substances around the air conditioner vents in the 200 hallway, and the entrance of the 400 hallway and the air conditioner vents throughout the 400 hallway. There were carpet	A 077		

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A 077	Continued From page 84	A 077		

stains throughout and entire facility and in resident's rooms and the carpet throughout the facility that looked dirty and had an odor. On at 6:15 a.m., splattered food particles were seen on the wall and base board under the window of the memory care nurse's station. On at 1:35 p.m. the splattered food was still present. All of the physical plant concerns were shown to the maintenance director, who confirmed they existed. He said the air conditioner leaked into the hallway ceiling approximately two weeks ago. He said the leak was repaired and the ceiling needed to be repaired but he was the only maintenance staff. He said carpet companies looked at replacing the carpet and gave proposals, but the facility was waiting on the money from the owners.

9. On at 11:25AM, resident #6 stated the facility had increased their rates and he was concerned they would make him leave. His rate increased from $1650.00 per month to $3000.00 per month on . That was an increase of $1350.00 per month. He stated he was only given 2 a week notice. Review of the rate increase letter revealed the letter was signed by the former administrator and was not dated. The letter to resident #6 revealed the same amounts the resident had stated in his interview. Letters for 27 residents were provided. Eleven of the residents who received letters had already left the facility by .

10. Upon entry to the facility on , caregivers reported there were 58 residents in the facility. An admission-discharge log was provided. Review of the log found it contained admission dates or discharge dates between and . Current residents living in the facility on who were admitted prior to

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A 077	Continued From page 85 were not listed anywhere. Several current residents were documented as having been discharged. Several residents were listed with multiple admission and discharge dates. On [redacted] at 10:30 AM, the interim director stated that was the only log she had available. She confirmed many residents were listed as discharged who were still living in the facility and not all current residents were in the log. 11. Request to the review the personnel record for staff L, former administrator, found the facility did not have a record available for review. On [redacted] at 2:30 PM, the interim director as of [redacted], confirmed the previous administrator left the facility on [redacted], and said there was no record available for review. Request to review the record for resident #11 who had been discharged found the facility did not have a record available for review. On [redacted] at 11 AM, the interim director said the staff could not locate the record and said she did not recall the residing in the facility. On [redacted] at 12 PM, staff E, a caregiver said she did recall resident #11 residing at the facility in the secured memory care unit. Class II	A 077		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable [redacted]. The examination performed by the health care provider must have	A 078		

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A 078	Continued From page 86 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 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	A 078		

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A 078	Continued From page 87 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 personnel record review and interview, the facility failed to ensure all staff providing services to residents were qualified to perform those duties in accordance with their level of training & education, and allowed unlicensed staff to administer medications to residents who were unable to self-administer (#1, #4, #5 & #10), and did not ensure 2 of 12 sampled employees presented documentation of freedom from communicable . . . . . g . . . . . ( ) (B & I). Findings: 1. Review of the personnel record for caregiver I, hired on . . . . . , found documentation of a . . skin test placed on . The form was blank for results of the test and the section for freedom from communicable was blank. The form was not signed by a licensed healthcare provider. Photographic evidence was obtained.	A 078		

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A 078	Continued From page 88 On at 2:30 PM, the marketing director appointed as interim director as of ... ... confirmed the finding. 2. On at 7:30 a.m., staff E was observed assisting resident #5 with ... . The staff member put a needle onto a ... , then handed it to the resident. The staff member instructed the resident to dial the pen to nine units, which he did. The resident then self-injected the ... into his abdomen. When asked immediately following the med pass why she put the needle onto the pen, which was a task unlicensed staff were not allowed to do, staff E said because she was taught in her medication assistance training that she was allowed to do so. 3. On at 11:23 a.m., staff D was observed assisting resident #4 with ... . The staff member put a needle onto a ... , ... then dialed the pen to ten units, both of which were tasks that unlicensed staff were not allowed to do. The resident self-injected the On at 11:36 a.m., when asked whether resident #4 was able to put a needle onto the pen and dial it herself, staff D said, "she can but when she's sleepy like she was then, she can't do it herself." On at 11:47 a.m., resident #4 said she was able to put a needle on the pen and could dial the pen herself, but staff just did it for her. 4. Observations on at 3:30 PM staff D an unlicensed caregiver, was observed taking resident #10's ... level. He removed	A 078		

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the , from the medication cart and placed the needle on the , and instructed resident #10 on how to use it. Staff D had to tell the resident to press the pen down on his to inject the . Staff D said at the time resident #10 was really not capable of doing his own without assistance. Staff D said he would take the resident's before providing the and there were no orders for it. He said he would do it on his own. Staff D said the nurses use to do the resident's and the past administrator informed the unlicensed staff that they would have to do it. He was not aware that he could not put the needle on the , and that it was required for the resident to be capable of doing it.

Resident #10's health assessment was not dated or signed by the health care provider and reflected that the resident needs nursing for "medication administration".

Review of the medication observation record (MOR) for , , 9/2021noted Solor star 100 unit/milliliter (ml.) 25 units every evening. The MOR noted the unlicensed staff were initialing the MOR as giving the medication at 4 PM.

5. Personnel record review for staff C, the resident care coordinator, hired , had an statement that noted a negative test result. Further review of the document revealed it was not signed or dated by a health care provider as evidence of freedom of communicable and .

On at 4 PM, the marketing director in charge confirmed the findings.

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A 078	Continued From page 90 6. Resident #1's health assessment, dated , listed diagnoses of an advanced 's, and type 2 . He had slow cognition. He needed assistance with self-administration of medications. The health assessment, dated , listed diagnoses of ( ). He was forgetful and was a risk. He needed assistance with all activities of daily living and medications. The MOR listed take 30 units every morning and 25 units in the evening, was marked as given at 8 AM and 4 PM, and indicated on at 8 AM " low -held per np order". The signatures on the bottom of the MOR identified the staff as unlicensed caregivers medication technicians (med techs). The MOR listed 30 units every morning and 25 units in the evening and was marked as given at 8 AM and 4 PM daily except on at 4 PM, , at 8 AM , at 4 PM. On , and at 8 AM was held - low; on 724 at 8 AM 67 - "not given ". The signatures on the bottom of the MOR identified the staff as unlicensed caregivers med tech. On at 11:15, the interim executive director said the pharmacy had sent her a report and she noted that staff D, who was not a nurse, held the . Class III	A 078		
A 079 SS=D	59A-36.010(3) FAC Staffing Standards - Levels	A 079		

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A 079	Continued From page 91 (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 6-15 212 16-25 253 26-35 294 36-45 335 46-55 375 56-65 416 66-75 457 76-85 498 86-95 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night.	A 079		

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A 079	Continued From page 92 5. A staff member who has completed courses in First Aid and , , ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least , , must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted.	A 079		

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A 079	Continued From page 93 (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time	A 079		

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A 079	Continued From page 94 specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on staff schedule review, staff time sheet review, shower log review, and interview, the facility failed to ensure staffing levels met the minimum staffing requirements in , and did not provide staffing to meet the needs of the residents in , . Findings: Staff schedules and time sheets were reviewed for the week of , , 2021. Staff hours required were 498 for the reported 83 residents that week. Review of the time sheets provided showed the facility had a total of 442.5 staff hours	A 079		

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A 079	Continued From page 95 from . . ./2021 which does not meet the minimum staffing requirement. Staff hours for the week of were reviewed. Staff hours required were 416 for the reported 58 residents that week. The staff scheduled showed 468 hours were scheduled, but residents complained they were not getting showers due to not enough staff available. Resident #4's assessment form, dated . . . . , indicated the resident required assistance by staff with bathing. Review of the facility's shower schedule revealed resident #4 was scheduled to receive a shower on . . . . . On . . . . at 10:08 a.m., resident #4 said she did not receive a shower on and said staff Q told her on . . . that she could not give the resident a shower because the facility was short staffed but that she would try to give the resident one on , however, the resident said she did not receive one on that date either. On . . at 10:34 a.m., staff Q said she did not assist resident #4 with a shower on either or . . . . because the facility was short staffed and too busy. Review of the staffing schedule revealed four staff were scheduled to work on . . . . and five staff on . Review of the facility's shower schedule revealed it noted resident #9 was to receive showers on Monday and Thursdays from the 3 PM-11 PM staff.	A 079		

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A 079	Continued From page 96 Resident #34 was to receive a shower on Monday and Thursdays from the 7 AM-3 PM staff. On at 9:45 AM, resident #9 said he was to receive showers on Monday's and Thursdays. He said he did not receive a shower last week at all. It was the Thursday prior to last week. He said the staff did not have time to give him a shower and he was unable to give himself a shower. On at 10: 15 AM resident #34 said he received assistance with shower, and he did not recall getting a shower on as he was supposed to. On at 10:30 AM, staff E, a caregiver who provided assistance with medication, said they did give resident #9 his shower today. She said he did not get one yesterday because she did not have time to give it. He requires 2 person assist with showers and sometimes there is not enough staff available to provide showers. She confirmed resident #34 did not receive a shower because they did not have time to get to him. On at 10:45 AM, staff V, a caregiver, said she worked 7 AM-3 PM and 3 PM -11 PM on . She said she was not able to give showers to every resident because they had other things to do because they were short staff. She said they had to do dining. She said she was not able to give a shower to residents #9 and #34 because the staff did not have time to. She said resident #9 required 2 person assist and resident #4 required a 3 person assist. She said they tried to do what they could. On at 3 PM, the marketing director, who was in charge, was not aware the residents	A 079		

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A 079	Continued From page 97 were not getting their showers as required. Class III	A 079		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1).	A 081		

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A 081	Continued From page 98 (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation.	A 081		

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A 081	Continued From page 99 (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident . . . . ., neglect, and , . The facility must use its . . . . . prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by:	A 081		

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A 081	Continued From page 100 Based on personnel record review and interview, the facility failed to ensure 1 of 12 direct care staff had received the required training within 30 days of hire (I). Findings: Review of caregiver I's personnel record revealed a hire date of . . . . . There was no documentation that she had completed training in the facility's policies and procedures related to preventing and reporting , neglect, and On . . . . . at 2:30 PM, the marketing director, appointed as interim director as of , confirmed the finding. Class III	A 081		
A 083 SS=D	59A-36.011(5) FAC Training - First Aid and . (5) FIRST 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.	A 083		

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A 083	Continued From page 101 (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 observations, interview and records review the facility failed to ensure a staff member who had completed courses in First Aid and , , ( ) and held a currently valid card documenting completion of such courses was always in the facility when residents were present for 3 of 6 sampled staff (H, I & X). Findings: Review off the facility staff schedule for the week of to 9 /18/21 revealed staff H, I and X worked the 11 PM to 7 AM shift. Individual personnel record review for staff I and X revealed no evidence to confirm they completed courses on /First Aid. Staff X had a certificate dated that indicated she attended an on-line First Aid part 2 training. The training was not from an approved provider and was not on. Staff H had that expired on . When staff I, H and X worked together on and from 11 PM -7 AM, there was no staff present in the facility that had current /First Aid certification. When staff I and H worked together on , there was also no staff present in the facility that	A 083		

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A 083	Continued From page 102 had current /First Aid. On at 4:15 PM, the interim executive director said she had no additional documentation; the staff did not have the /First Aid training and they all needed training. The interim executive director was told that she had to have someone cover the 11 PM to 7 AM shift that had the required certification in first Aid and until the above staff receive the required certifications. Class III	A 083		
A 084 SS=D	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and	A 084		

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A 084	Continued From page 103 procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, , dosage forms, and , , and dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with syringes that are prefilled with the proper dosage by a pharmacist and , that are prefilled by the	A 084		

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A 084	Continued From page 104 manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection; i. Assist with [illegible]; j. Use a [illegible] to perform [illegible] testing; k. Assist residents with [illegible] and continuous positive airway pressure (CPAP) devices, excluding the titration of the [illegible] levels; l. Apply and remove [illegible] stockings and hosiery; m. Placement and removal of [illegible] bags, excluding the removal of the [illegible], or manipulation of the [illegible] site; and, n. Measurement of [illegible], [illegible], [illegible] rate, temperature, and [illegible] rate. (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n.	A 084		

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A 084	Continued From page 105 429.52 (6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training This Statute or Rule is not met as evidenced by: Based on personnel record review and interview the facility failed to ensure 2 of 12 sampled unlicensed staff (D & K), who assisted with medications had completed the required training pertaining to assistance with self-administered medications and safe medication practices. Findings: 1. Personnel record review for staff D revealed he was hired on . A certificate dated . . . . . indicated he attended the initial 4-hour training in providing assistance with self -administration of medications. The review revealed a certificate dated that indicated a 2-hour update, certificates dated . . . . and indicated a 1 hour each of training. the review revealed no evidence to confirm the staff, who successfully completed 4 hours of assistance with self-administration of medication training completed an additional 2 hours of training that focused on the topics listed in sub-subparagraphs (6)(b)2. h.-n. of this section, before assisting with the self-administration of medication procedure. There was no evidence to confirm he attended a 2-hour update in 2021.	A 084		

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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
A 084	Continued From page 106 In an interview with the interim executive director on at 4:15 PM who said she had no additional documentation; the staff had not taken the required training. 2. Staff K's personnel record review revealed a hire date . There was no documented evidence of the initial 6 hour medication training found in the file. On at 11:10 AM, an interview with resident #8, very upset stating that staff K almost tried to kill him by trying to assist giving him triple amount dose of medications at same time of the morning of . Resident #8 stated that he stopped staff K and only took the one dose prescribed because he is aware of what his medications are and how he should take them. On at 11:50 AM, interviewed the Resident Care Coordinator about the concern resident #8 voiced. The Resident Care Coordinator confirmed that the incident did happen between staff K and resident #8 and that staff K no longer worked at the facility, terminated on . She stated that the facility wrote an incident report of what happened. On at 1:30 PM, reviewed the , Medication Observation Record (MORs) showing that staff K did assist with self-administration of medications to resident #8 on . Furthermore, staff K was terminated on and unable to interview. Photographic evidence was obtained. Resident #8's record review revealed admission date . The AHCA Form 1823 Health Assessment dated listed medical conditions of ,	A 084		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11953542	A. BUILDING: _____ B. WING _____	C 09/24/2021

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A 084	Continued From page 107 type 2 no .. .. but oral medication, ... Defibrillator and Activity of Daily Living (ADLs) with independent in all. He needs assistance with self-administration of medications. There were no physician orders found in resident #8's record and no facility note for clarification found. Photographic evidence was obtained. On .. . . . . at 5:45 PM, the Interim Administrator confirmed the findings. Class III	A 084		
A 093 SS=B	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are incorporated by reference and available for review at: http://iom.edu/Activities/Nutrition/SummaryDRIs/~/media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%2014.pdf. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a	A 093		

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A 093	Continued From page 108 licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to	A 093		

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A 093	Continued From page 109 document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of ◡ the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has . . . . . with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the local	A 093		

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A 093	Continued From page 110 disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observations, review of dietary records and interview, the facility failed to follow its dated menus, and failed to document substitutions before or at the time a meal was served. Findings: On [redacted] at 11:54 a.m., staff were seen serving the residents salad, green beans, salmon, tilapia, and potatoes. Review of the posted menu revealed it was week five and it indicated lunch would be salad, Salisbury steak, parmesan pasta, lemon pepper, green beans, and baked roll. However, the menu dates were on a separate paper and revealed week three menu was supposed to be used for the week of [redacted]/21. In addition, review of the substitution log revealed the lunch items served were not listed on the log. On [redacted] at 1:35 p.m., the dietary manager confirmed the findings and was unable to provide additional documentation. Class	A 093		