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
	AL11967024	A. BUILDING: _____ B. WING _____	09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA GRANDE BELLE	5898 ORCHARD POND ROAD TALLAHASSEE, FL 32303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced biennial licensure survey including generator assessment and Limited Mental Health was conducted at La Grande Belle Assisted Living Facility in Tallahassee, Florida on . At the time of the survey, deficiencies were identified.	A 000		
A 008 SS=F	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, 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	A 008		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 008	Continued From page 1 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 Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or [illegible] 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	A 008		

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A 008	Continued From page 2 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 [illegible] require such assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a [illegible]-to-[illegible] 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: 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,	A 008		

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A 008	Continued From page 3 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, , 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 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	A 008		

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A 008	Continued From page 4 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 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.	A 008		

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A 008	Continued From page 5 This Statute or Rule is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to obtain, update, and complete the Resident Health Assessment for Assisted Living Facilities (AHCA Form 1823) for 5 of the 5 residents residing at the facility (#1, #2, #3, #4 and #5). The findings include: On at approximately 10:00 AM, a copy of the most recent Resident Health Assessment for Assisted Living Facilities (form 1823) was requested for 5 of 5 residents residing at the facility. Staff Member A, medical assistant and lead staff, was unable to locate the forms for review for Resident #1 and Resident #2. On a review of the Resident Health Assessment for Assisted Living Facilities (form 1823) was conducted for Resident #3. The form was signed by the physician on [redacted]. Section 3 entitled "Services Offered or Arranged by the Facility for the Resident" was blank despite the following instructions: "This section must be completed for all residents and must be based on needs identified in section 1 & 2 of the form. The facility may attach service plans, care plans, community living support plans, to the form to satisfy the requirement provided that the documentation corresponds with the information in section 3". No other documentation was attached to the form. On a review of the Resident Health Assessment for Assisted Living Facilities (form 1823) was conducted for Resident #4. The form	A 008		

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A 008	Continued From page 6 was signed by the physician on . . . . . Section 3 entitled "Services Offered or Arranged by the Facility for the Resident" was blank despite the following instructions: "This section must be completed for all residents and must be based on needs identified in section 1 & 2 of the form. The facility may attach service plans, care plans, community living support plans, to the form to satisfy the requirement provided that the documentation corresponds with the information in section 3". No other documentation was attached to the form. On , a review of Resident Health Assessment for Assisted Living Facilities (form 1823) was conducted for Resident #5. The form was signed by the physician on . . . . . The form was completely blank in all sections and no additional information was attached. On . . . . . at 12:50 PM, an email was sent to the Administrator per his request, with a list of documents needed for review. The email read but was not limited to "At the time of your biennial licensure survey, (the Lead Staff, Staff A) was unable to provide us information and documentation. She indicated that you were out of town at the time and unable to provide the information at the time of request. She revealed you telephoned her and requested the information be sent to you by email, so that you can provide by the end of the day. Please note per the regulation, these items must be available at the time of the survey and therefore deficiencies will be cited for not being available onsite. However, here are a list of documents that we were unable to find in your facility records." Form 1823 was included in this request for all 5 residents residing in the facility.	A 008		

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A 008	Continued From page 7 On . . . . . at approximately 2:30 PM, an interview was conducted with the Staff Member A. She was notified that a Resident Health Assessment for Assisted Living Facilities (form 1823) was required to be completed prior to a resident's admission to the facility. She was also notified that the form should always be updated for any changes in the resident's medications, treatments, or health status as well. Staff Member A was unable to provide any additional documentation to show that the forms have been obtained, completed, or updated. On at approximately 2:45 PM, review of the facility's policy titled, "Medical Requirements for Residents & Pharmacy Choice" was conducted. The policy stated that all residents are to have a completed form 1823 on file prior to admission to the facility. On . . . . . at approximately 3:45 PM, a telephone interview was conducted with the Administrator. He was asked about missing records and informed an email, per his request, had been sent at 12:50 PM, with a list document needed by the surveyors. Form 1823 was on the list of requested documents. At the time of exit on . . . . . at approximately 5:10 PM, the Administrator had not sent any of the requested records to the surveyors. Class III	A 008		
A 025 SS=I	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician	A 025		

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A 025	Continued From page 8 when a resident exhibits signs of [illegible] or [illegible] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [illegible] or [illegible]. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making [illegible] for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's	A 025		

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A 025	Continued From page 9 family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to establish a tobacco use policy to ensure residents who smoked were safe from harm. The facility failed to ensure residents who smoked tobacco products were assessed to determine the residents were safe to smoke without supervision and failed to provide safety preventions such as ashtrays for residents' use when smoking for 4 of 4 residents reviewed for smoking safety (#1, #2, #3, #4). These failures have the potential to place all 5 of the facility residents at risk for serious injury/ , . / from and fire. The findings include: On ..... at approximately 9:20 AM, 3 residents were observed smoking on the porch of the facility. There were multiple . . holes noted in the seats of the outdoor furniture that the residents sat in. Resident #1 was using a plastic bowl for an ash tray. Resident #3 was using what appeared to be tin foil placed in a metal garbage can as an ash tray. Resident #4 was using what	A 025		

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A 025	Continued From page 10 appeared to be the plastic lid of a peanut butter jar as an ash tray. The porch had a "No Smoking Sign" posted. None of the 3 residents were observed to be wearing smoking aprons at the time of the observation. (Photographic evidence was obtained) On at approximately 10:00 AM, an interview was conducted with Resident #1. He was asked if he ever had access to a real ashtray. He explained that he has not had an ashtray to use for a while. He explained that one of the other residents throws the ash trays out and they have not received new ones from facility staff in sometime. He was asked if he carried his lighter with him. Resident #1 mentioned that staff allow most of the residents to have their lighters. He explained that Resident #2 is the only resident that does not have a lighter in his possession. He also explained that Resident #3 has several lighters. On at approximately 12:00 PM, the surveyor observed Staff Member A, medical assistant and lead staff, assist Resident #2 to take his medication. Staff Member A mentioned that Resident #2 had a history of . When Resident #2 took his medicine, Staff A said that the medication was for . Staff Member A stated that staff had to watch resident #2 closely because he has very bad all the time. On at approximately 12:45 PM, Resident #2 was observed to be outside smoking on the porch without staff supervision. On at approximately 1:10 PM, an interview was conducted with Staff Member A, medical assistant and lead staff. She was asked	A 025		

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A 025	Continued From page 11 to describe the process for assessing and monitoring residents for safety when smoking. She explained that residents are not formally assessed for smoking safety. She stated that all the residents except Resident #2 were able to keep a lighter with them. She further stated that staff go outside periodically (about every hour) to check on the residents in the smoking area. On at approximately 3:25 PM, the administrator revealed the facility did not have any policies or procedures related to smoking. He confirmed one of the items being used by the resident to put ashes in was an old metal trash can with foil inserted to drop ashes and this is what residents should be using. He indicated that the designated smoking area was the porch. He was informed that a resident was observed to be putting cigarettes out in plastic top from a jar and plastic bowl, and he indicated "well that resident decided to do that he should be using the metal trash can". He was asked if he or any staff performed smoking assessments to ensure residents were safe to smoke unsupervised and keep their smoking materials with them and he indicated he had never heard of such thing for an ALF (Assisted Living Facility). He stated he was the person that determined the residents were safe to smoke without supervision because "in my opinion if they can put a pill to their they can smoke." He indicated all residents could smoke unsupervised and keep their own smoking materials to include cigarettes and lighters. Class II	A 025		
A 077 SS=I	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators	A 077		

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A 077	Continued From page 12 429.176 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 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];	A 077		

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A 077	Continued From page 13 2. If employed on or after . . . . . , . . . , 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. 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	A 077		

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	AL11967024	A. BUILDING: _____ B. WING _____	09/28/2021

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A 077	Continued From page 14 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 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 resident record review, facility record review, observations, and interview, the facility's Administrator who is responsible for operation of the facility failed to ensure management of all	A 077		

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A 077	Continued From page 15 staff and the provision of appropriate care and safety of all residents. The Administrator failed to ensure the following: 1. Residents were assessed to determine if residents were deemed safe to smoke unsupervised and offer appropriate supervision personalized to the individual residents for 5 of 5 total residents. 2. Develop and implement written policies and procedures to ensure the facility can effectively and immediately activate, operate, and maintain the alternate power source and store the required 48 hours of fuel to operate to alternate power source onsite for a licensed capacity of 16 beds or less. 3. Maintain a safe living environment for 5 of 5 total residents residing in the facility. 4. Resubmit the CEMP plan for review and approval by the local Emergency Management Agency 5. Maintain evidence of a negative ( ) examination and a communicable statement for 3 of 6 staff reviewed (Administrator, Staff A and B). 6. Conduct staff preservice orientation for 4 of 5 (A, C, D, E) staff reviewed and the facility failed to provide trainings required within 30 days of employment for 2 of 5 staff (A, B). 7. At least 1 staff is working in the facility at all times with First Aid and , , ( ) for 5 of 6 staff reviewed (Administrator, Staff B, C, D, and E). 8. Provide evidence of training certificates for 6 of 6 staff that demonstrate staff received a minimum of 6 hours training before providing assistance for 6 of 6 staff reviewed. (Administrator, Staff A, B, C, D, and E) 9. Provide Training ( ) within 30 days of employment for 1 of 5	A 077		

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A 077	Continued From page 16 staff (Staff B). 10. Maintain Limited Mental Health (LMH) records to ensure required documentation pursuant to 429.075, 59A-36.020, and 59A-36.011, F.A.C. was available for review by the State Agency for 2 of 2 LMH residents. (#2 and #4). Ensure at least 6 hours of Limited Mental Health (LMH) training related for their duties for 3 of 3 employees that have been employed with the facility for 6 months of more. (Administrator, Staff A, and Staff B) 11. Maintain within their personnel records the eligibility results of employee screening for 4 of 6 staff (Administrator, Staff C, D, and E). 12. Maintain the employment status of all employees within the clearinghouse within 10 business days for 5 of 9 staff reviewed (A, B, F, G, and H). 13. Every employee completed an Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008 for 4 of 6 employees reviewed (Administrator, Staff C, D, and E). 14. Ensure at least one staff member was always in the building with access to facility and resident records in case of an emergency. Also failed to ensure a staff member who was at least , had been designated in writing during periods of the Administrator's temporary absence for more than 48 hours to serve in the role of the Administrator. 15. The facility staff failed to routinely screen visitors and employees for symptoms of and exposure to COVID-19. 16. Failed to plan and post menus at least 1 week in advance in an area that is accessible to 5 of the 5 residents residing at the facility. The facility also failed to maintain records of meals served at facility for the previous 6 months and maintain an adequate 3-day supply of non-perishable food based on the resident census.	A 077		

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A 077	Continued From page 17 The findings were: Please refer to the following deficiencies: A0008- Admissions- Health Assessment- Class III A0025- Resident Care-Supervision-II A0077- Staffing Standards- Administrators- Class II A0078- Staffing Standards-Staff- Class III A0079- Staffing Standards-Levels- Class II A0081- Training- Staff In-Services- Class III A0083- Training- First Aid and [illegible] - Class II A0084- Training-Assistance with Self Administration of Medication and Medication Management. Class III A0090- Training-[illegible]-Class III A0093- Food Service-Dietary Standards- Class III A0152- Physical Plant-Safe Living Environment and other Requirements- Class III A0160- Records- Facility- Class III A0200- Emergency Environmental Control- Class II A-L241- LMH- Records- Class III AL243- LMH-Training-Class III C-Z813- Results of Screening & Notification In File- Unclassified C-Z814- Background Screening Clearinghouse-Unclassified C-Z816- Background Screening-Compliance Attestation- Unclassified C-Z830 - Emergency Management Planning - Class III Class II	A 077		
A 078 SS=E	59A-36.010(2) FAC Staffing Standards - Staff	A 078		

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A 078	Continued From page 18 (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their assigned duties consistent with their level of 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	A 078		

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A 078	Continued From page 19 observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility . . . . . to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on personnel record review, staff interview, and policy review, the facility failed to maintain evidence of a negative . . . . . ( ) examination and a communicable statement for 3 of 6 staff reviewed (Administrator, Staff A and B). The findings include: On at approximately 11:22 AM, a request was made for personnel records for the Administrator and employees A-E from staff A, medical assistant and lead staff. Staff A provided the surveyor personnel records for 3 staff to	A 078		

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A 078	Continued From page 20 include herself, staff B and Staff C. Staff A stated she did not have access to the Administrator's personnel record and surveyors would need to request them from him directly as he did not live in town. Staff A stated she had called the administrator and he informed her to ask that surveyors send him an email requesting any documents that were needed and he would send by the end of the day. Record review of all personnel records revealed the following: Staff A, medical assistant and lead staff, had a date of rehire as . Staff A's personnel record failed to reveal evidence of a negative examination or a communicable statement. Staff B, direct care, had a date of hire of . Staff B's personnel record failed to reveal evidence of a negative examination or a communicable statement. The Administrator's personnel record was not available at the time of the survey. On at approximately 1:00 PM, an interview was conducted with Staff A, who was asked if she could provide evidence of a examination and/or communicable statement for any of the personnel records being reviewed and she indicated she provided surveyors with all the records she had. She stated upon hire staff were not asked to provide documentation of or communicable statements. Staff A was asked if she had obtained a examination and communicable statement from a physician when she was re-hired and she indicated she had not.	A 078		

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A 078	Continued From page 21 On at 12:50 PM, an email was sent to the Administrator per his request, with a list of information needed to complete the re-licensure survey. The email read but was not limited to "At the time of your biennial licensure survey, (the Lead Staff, Staff A) was unable to provide us information and documentation. She indicated that you were out of town at the time and unable to provide the information at the time of request. She revealed you telephoned her and requested the information be sent to you by email, so that you can provide the requested documents by the end of the day. Please note per the regulation, these items must be available at the time of the survey and therefore deficiencies will be cited for not being available onsite. However, here are a list of documents that we were unable to find in your facility records." This email included . . examinations and communicable statements for all staff. Review of the facility's policy titled "Medical requirements for staff" states but not limited to "All staff/volunteer must have on file free of communicable and within 30 days from the date of hire." At the time of exit on . . . . . at approximately 5:10 PM, the Administrator had not sent any of the requested records to surveyors. Class III	A 078		
A 079 SS=I	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum	A 079		

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A 079	Continued From page 22 staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 212 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. 5. A staff member who has completed courses in First Aid and , , ( ) and holds a currently valid card	A 079		

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A 079	Continued From page 23 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. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of	A 079		

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A 079	Continued From page 24 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 specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed	A 079		

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A 079	Continued From page 25 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 resident record review, facility record review, observations, and interview, the facility failed to ensure at least one staff member was always in the building with access to facility and resident records in case of an emergency. The facility's Administrator failed to designate in writing during periods of his temporary absence for more than 48 hours, a staff member who was at least , to serve in the role of the Administrator. This failure has the potential to effect all residents that reside in the facility. The findings include: On at approximately, 8:50 AM, surveyors entered the facility and Staff A, medical assistant and lead staff, was the only staff present at the	A 079		

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A 079	Continued From page 26 facility. During the entrance conference at approximately 9:10 AM, Staff A indicated that she was not the Administrator or the Manager, but just the lead staff. She revealed the facility's Administrator lived in south Florida. On [redacted] during multiple interviews with staff A (11:22 AM, 12:20 PM, 1:45 PM, 2:45 PM), residents records and facility records were requested to no avail. Staff A was not able to fill the role of the Administrator and demonstrate compliance by providing this information to state surveyors. Staff A had no knowledge on how to operate the facility's generator should the power go out and indicated if the power went out, she was instructed to contact the Administrator, who lived in South Florida. Staff A could not locate fuel for the facility's generator and indicated it may be in a silver shed located in the backyard of the facility, but the shed was observed by surveyor and staff A to be locked. Staff A revealed she did not have a key to unlock the shed to determined if there was fuel available. Staff Member A was asked to explain the process for assessing and monitoring residents for safety when smoking and she was unable to do so. Staff A was asked if the facility had any current Limited Mental Health residents, and she was unable inform surveyors where this documentation could be located. Staff A was asked for a copy of the Clearing House Background Screening Roster, and she indicated she did not have access only the administrator who was out of town at the time. She stated she would attempt to call him and see if he could provide access. Access was never granted during the survey to staff. A request was made for personnel records for the Administrator and staff A-E from staff A. Staff A provided the surveyor personnel records for 3 staff to include herself, staff B and Staff C. She revealed she only had	A 079		

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	AL11967024	A. BUILDING: _____ B. WING _____	09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA GRANDE BELLE	5898 ORCHARD POND ROAD TALLAHASSEE, FL 32303

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A 079	Continued From page 27 applications for Staff D and Staff E and provided those to the surveyor. Staff A stated she did not have access to the Administrator's personnel record and surveyors would need to request from him directly as he did not reside in town. Staff A stated she had called the administrator and he informed her to ask that surveyors to send him an email of any documents that were needed and he would send the requested documents by the end of the day. Staff A revealed she was the lead staff and responsible for hiring employees in the absence of the administrator. She reported that she made a lot of decisions but had not been trained on all operations that would be the responsibility of an administrator. She reports that the administrator comes to the facility maybe weekends a month. She indicated she does not have access to facility information and has to text or call the administrator when needed. She apologized for not being able to better help the surveyors and provide missing resident and facility records. She indicated she has not received core training nor any direct training from the Administrator on the facility's operations. Staff A was also unable to provide an updated Fire Inspection and Comprehensive Emergency Management Plan (CEMP). On ..... at 12:50 PM, an email was sent to the Administrator per his request of information that was missing. The email read but was not limited to "At the time of your biennial licensure survey, (the Lead Staff, Staff A) was unable to provide us information and documentation. She indicated that you were out of town at the time and unable to provide the information at the time of request. She revealed you telephoned her and requested the information be sent to you by email, so that you can provide by the end of the day. Please note per the regulation, these items must be	A 079		

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A 079	Continued From page 28 available at the time of the survey and therefore deficiencies will be cited for not being available onsite. However, here are a list of documents that we were unable to find in your facility records." This request included a request for resident and facility records. On at approximately 3:20 PM, Staff A was asked if she could call the Administrator, because surveyors needed to speak to him regarding information that she was unable to provide. She contacted the Administrator on the facility's telephone and handed the telephone to surveyors. On at approximately 3:25 PM, an interview was conducted with Administrator via telephone. The Administrator revealed that he tried to visit the facility at least every other week and his visits may range from days depending on what is happening. The Administrator was asked if he had designated in writing a manager that would fill his role when he was absence for more than 48 hours and he stated, "No". He was asked if Staff A was filling that role and he stated, "she is just the lead staff and in charge of day to day operation in my absence, but I make all the decisions, I am the Administrator." The Administrator was asked if any other person 21 years or older had been designated to perform the administrator role in his absence and he revealed he had not designated anyone. He also revealed he had not trained Staff A to perform all administrative duties, but she was the one responsible for hiring and terminating staff, purchasing groceries with facility funds, caring for residents, and some other lead duties that he had assigned, but iterated "I am the Administrator". Class II	A 079		

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A 081 SS=F	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). (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	A 081		

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A 081	Continued From page 30 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. (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:	A 081		

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A 081	Continued From page 31 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: Based on personnel record review and interview, the facility failed to provide staff preservice orientation for 4 of 5 (A, C, D, E) staff reviewed. The facility also failed to provide several trainings required within 30 days of employment for 2 of 5	A 081		

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A 081	Continued From page 32 staff (A, B). The findings include: On ..... at 11:22 AM, a request was made for personnel records for the Staff A-E from staff A, medical assistant and lead staff. Staff A provided the surveyor personnel records for 3 staff to include herself, staff B and Staff C. She revealed she only had applications for Staff D and Staff E and provided those to the surveyor. Staff A stated she had called the administrator and he informed her to ask that surveyors to send him an email of any documents that were needed and he would send by the end of the day. Record review of the personnel records the following missing staff training: Staff A, medical assistant and lead staff, had a date of rehire as . Staff A's primary shift is 7 AM to 3 PM, Monday through Friday. Staff A's personnel record revealed there was no evidence of Activities of Daily Living (ADL) and Behavioral Needs Training. Staff A's personnel record revealed there was no Preservice Orientation or Control, which must be completed prior to interacting or providing personal care to residents. Staff B, direct care, had a date of hire of . Staff B's primary shift was 8 PM to 7 AM. Staff B's personnel record revealed there was no evidence of ADL and Behavioral Needs Training, Elopement Response Training; Reporting Major Incidents/Reporting Adverse Incidents/Facility Emergency Procedures Training; Incident Reporting training, and Nutritional and Safe Food Handling. Staff C, direct care staff, had a date of hire of	A 081		

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A 081	Continued From page 33 . . . . . Staff C's personnel record revealed there was no Preservice Orientation or Control, which must be completed prior to interacting or providing personal care to residents. This staff was still within the 30-day time of employment time frame for all additional trainings required. Staff D, direct care staff, had a date of rehire as . Staff D's personnel record revealed there was no Preservice Orientation or Control, which must be completed prior to interacting or providing personal care to residents. This staff was still within the 30-day time of employment time frame for all additional trainings required. Staff E, direct care staff, had a date of rehire as . . . . . Staff E's personnel record revealed there was no Preservice Orientation or Control, which must be completed prior to interacting or providing personal care to residents. This staff was still within the 30-day time of employment time frame for all additional trainings required. A review of the . . . medication observation records (MOR) for residents #1, #2, #3, #4, #5 revealed Staff B, C, D, and E to have worked several days as they had initialed their records as assisting with medication administration. On at 12:50 PM, an email was sent to the Administrator per his request of information that was missing. The email read but was not limited to "At the time of your biennial licensure survey, (the Lead Staff, Staff A) was unable to provide us information and documentation. She indicated that you were out of town at the time and unable	A 081		

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A 081	Continued From page 34 to provide the information at the time of request. She revealed you telephoned her and requested the information be sent to you by email, so that you can provide by the end of the day. Please note per the regulation, these items must be available at the time of the survey and therefore deficiencies will be cited for not being available onsite. However, here are a list of documents that we were unable to find in your facility records." The email list included missing trainings for each staff (A-E). On [redacted] at approximately 3:25 PM, an interview was conducted with Administrator in which he requested that the surveyor send him an email with documentation of training that was missing from personnel records. This surveyor informed the Administrator that an email had already been sent at 12:50 PM, but to date had not received any information. The administrator revealed he was not able to send at the time because he was driving home from his job as a teacher out of town. At the time of exit on [redacted] at approximately 5:10 PM, the Administrator had not sent any of the requested records to the surveyors. Class III	A 081		
A 083 SS=H	59A-36.011(5) FAC Training - First Aid and [redacted] (5) FIRST AID AND [redacted] ([redacted]). A staff member who has completed courses in First Aid and [redacted] 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	A 083		

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A 083	Continued From page 35 current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on personnel record review, medication observation records (MOR), staff interview, and policy review, the facility failed to ensure at least 1 staff is working in the facility at all times with First Aid and ( ) for 5 of 6 staff reviewed (Administrator, Staff B, C, D, and E). The findings include: On at 11:22 AM, a request was made for personnel records for the Administrator and employees A-E from staff A, medical assistant and lead staff. Staff A provided the surveyor personnel records for 3 staff to include herself, staff B and Staff C. She revealed she only had applications for Staff D and Staff E and provided those to the surveyor. Staff A stated she did not have access to the Administrator's personnel record and surveyors would need to request from him directly as he did not live in town. Staff A stated she had called the administrator and he	A 083		

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A 083	Continued From page 36 informed her to ask that surveyors to send him an email of any documents that were needed and he would send by the end of the day. Record review of all personnel records revealed the following: The Administrator's personnel record was not available at the time of the survey. Staff A, medical assistant and lead staff, had a date of rehire as . Staff A's primary shift was 7 AM to 3 PM, Monday through Friday and any time staff were not able to work, she most times coved the shift. This staff was the only staff in the building with a valid certification and First Aid, with an expiration of . Staff B, direct care, had a date of hire of . Staff B's primary shift was 8 PM to 7 AM. Staff B's personnel record revealed there was no evidence of First Aid and certification. Staff C, direct care staff, had a date of hire of . Staff C's primary shift was 3 PM to 8 PM, 3 days a week. Staff C's personnel record revealed there was no evidence of First Aid and certification. Staff D, direct care staff, had a date of rehire as . Staff D's primary shift was 7 AM to 3 PM, every other weekend. Staff D's personnel record revealed there was no evidence of First Aid and certification. Staff E, direct care staff, had a date of rehire as . Staff E's primary shift was 3 PM to 8 PM, opposite days of Staff C. Staff E's personnel record revealed there was no evidence of First Aid and certification. On a follow-up interview was conducted with Staff A at approximately 12:00 PM, during which she indicated that Staff B, C, D, and E all work alone. She revealed she was not aware of any other staff that had /First Aid training and	A 083		

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A 083	Continued From page 37 that she had no additional information to provide to surveyors than what had already been provided. On . . . . . at 12:50 PM, an email was sent to the Administrator per his request of information that was missing. The email read but was not limited to "At the time of your biennial licensure survey, (the Lead Staff, Staff A) was unable to provide us information and documentation. She indicated that you were out of town at the time and unable to provide the information at the time of request. She revealed you telephoned her and requested the information be sent to you by email, so that you can provide by the end of the day. Please note per the regulation, these items must be available at the time of the survey and therefore deficiencies will be cited for not being available onsite. However, here are a list of documents that we were unable to find in your facility records." . . and First Aid Certification was requested in this email. A review of the , medication observation records (MOR) for residents #1, #2, #3, #4, #5 revealed Staff B, C, D, and E to have worked several days as they had initialed their records as assisting with medication administration. A follow-up interview on . . . . . at approximately 1:45 PM, with staff A revealed she was the lead staff and responsible for hiring employees in the absence of the administrator. She reported that she made a lot of decisions but has not been trained on all operations that would be the responsibility of the administrator. She reports that the administrator comes to the facility maybe . . weekends a month. She indicated she does not have access to facility information and has to	A 083		

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A 083	Continued From page 38 text or call the administrator who lives out of town. She apologized for not being able to better help the surveyors and provide missing documentation. She indicated she has not received Core training nor any direct training from the facility on the facility's operations. On at approximately 3:25 PM, the administrator was informed that several staff trainings were missing from the personnel's records and he indicated he could send to surveyors by the end of the day if an email was sent. He indicated he could not at the time of the interview because he was heading home from his job as a teacher. The administrator was informed an email had already been sent to request documents per request of his lead staff and surveyors had not received any information. The administrator revealed he would get staff trained if he had to have them take online classes and obtain necessary documents but stated " I will accept a citation for this". At the time of exit on at approximately 5:10 PM, the Administrator had not sent any of the requested records to the surveyors. A review of the facility's /First Aid policy stated the following "All staff and administration must be and First Aid certified by the American Red Cross or American Association. All staff will be required to act in the even a resident needed life saving skills: however, resident who have chosen to have , shall be left alone and -1 is to be contacted immediately. If the administrator is not on the premises, contact the administrator following 911." Class II	A 083		

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A 084 SS=F	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 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;	A 084		

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A 084	Continued From page 40 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 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 ; j. Use a to perform testing; k. Assist residents with and continuous positive airway pressure (CPAP) devices, excluding the titration of the levels; l. Apply and remove stockings and hosiery; m. Placement and removal of , bags, excluding the removal of the or	A 084		

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A 084	Continued From page 41 manipulation of the site; and, n. Measurement of , , rate, temperature, and , 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. 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, , medication observation records (MOR), and interview, the facility failed to show proof of	A 084		

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A 084	Continued From page 42 training certificates for 6 of 6 staff that demonstrated staff received a minimum of 6 hours training before providing assistance for 6 of 6 staff reviewed. (Administrator, Staff A, B, C, D, and E) The findings were: On . . . . . at 11:22 AM, a request was made for personnel records for the Administrator and staff A-E from staff A, medical assistant and lead staff. Staff A provided the surveyor personnel records for 3 staff to include herself, staff B and Staff C. She revealed she only had applications for Staff D and Staff E and provided those to the surveyor. Staff A stated she did not have access to the Administrator's personnel record and surveyors would need to request from him directly as he did not live-in town. Staff A stated she had called the administrator and he informed her to ask that surveyors to send him an email of any documents that were needed and he would send the requested documents by the end of the day. Record review of the personnel records following this interview revealed: The Administrator's personnel record was not available at the time of the survey. Staff A, medical assistant and lead staff, had a date of rehire as . Staff A's primary shift was 7 AM to 3 PM, Monday through Friday. Review of staff A's personnel record revealed a certificate for 2 hours of continuing education for Self-Administration of Medications training. There was no evidence of the minimum of 6 hours training for self-administration of medication. Staff B, direct care, had a date of hire of . . . . . . Staff B's primary shift was 8 PM to 7 AM. Staff B's personnel record revealed a certificate for 2 hours of continuing education for	A 084		

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A 084	Continued From page 43 Self-Administration of Medications training. There was no evidence of the minimum of 6 hours training. for self-administration of medication. Staff C, direct care staff, had a date of hire of [redacted]. Staff C's primary shift was 3 PM to 8 PM, 3 days a week. Staff C's personnel record revealed there was no evidence of this staff completing the minimum of 6 hours training for self-administration of medication. Staff D, direct care staff, had a date of rehire as [redacted]. Staff D's primary shift was 7 AM to 3 PM, every other weekend. Staff D's personnel record revealed there was no evidence of this staff completing the minimum of 6 hours training for self-administration of medication. Staff E, direct care staff, had a date of rehire as [redacted]. Staff E's primary shift was 3 PM to 8 PM, opposite days of Staff C. Staff E's personnel record revealed there was no evidence of this staff completing the minimum of 6 hours training for self-administration of medication. On [redacted] at approximately 11:55 PM, a follow-up interview was conducted with Staff A. Staff A revealed that all staff administer medications during their shift and there is usually only 1 staff working per shift. She revealed that she would need to contact Staff D and Staff E to see if they have documentation of their training because she believed they both had recent training before starting employment with the facility. Staff A revealed she did not have access to any additional training records for any of the facilities 5 employees to include herself than what had previously been provided to surveyors. Review of [redacted] Medication Observation Records for resident #1, #2, #3, #4, #5, revealed initials from all staff except the Administrator (Staff A, B, C, D, E).	A 084		

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A 084	Continued From page 44 On at 12:50 PM, an email was sent to the Administrator per his request of information that was missing. The email read but was not limited to "At the time of your biennial licensure survey, (the Lead Staff, Staff A) was unable to provide us information and documentation. She indicated that you were out of town at the time and unable to provide the information at the time of request. She revealed you telephoned her and requested the information be sent to you by email, so that you can provide by the end of the day. Please note per the regulation, these items must be available at the time of the survey and therefore deficiencies will be cited for not being available onsite. However, here are a list of documents that we were unable to find in your facility records." This email included a request for self-administration of medication training for all facility staff. On at approximately 3:25 PM, the Administrator was informed that several staff trainings were missing from the personnel's records, and he indicated he could send to surveyors by the end of the day if an email was sent. He indicated he could not at the time of the interview because he was heading home from his job as a teacher. The Administrator was informed an email had already been sent to request documents per request of his lead staff and surveyors had not received any information. The Administrator revealed he would get staff trained if he had to have them take online classes and obtain necessary documents but stated " I will accept a citation for this". At the time of exit on at approximately 5:10 PM, the Administrator had not sent any of the requested records to the surveyors.	A 084		

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A 084	Continued From page 45 Class III	A 084		
A 090 SS=D	59A-36.011(11) FAC Training - (11) . . . . . TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding . (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to provide Training ( ) within 30 days of employment for 1 of 5 staff (Staff B). The findings include: On at 11:22 AM, a request was made for personnel records for the Staff A-E from staff A, medical assistant and lead staff. Staff A provided the surveyor personnel records for 3 staff to include herself, staff B and Staff C. Staff A stated she had called the administrator and he informed her to ask that surveyors to send him an email of any documents that were needed and he would send by the end of the day.	A 090		

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A 090	Continued From page 46 A review was conducted of the personnel record for Staff B, direct care, which revealed a date of hire of . Staff B's personnel record had no evidence of .. .. training. On .. .. .. at 12:50 PM, an email was sent to the Administrator per his request of information that was missing. The email read but was not limited to "At the time of your biennial licensure survey, (the Lead Staff, Staff A) was unable to provide us information and documentation. She indicated that you were out of town at the time and unable to provide the information at the time of request. She revealed you telephoned her and requested the information be sent to you by email, so that you can provide by the end of the day. Please note per the regulation, these items must be available at the time of the survey and therefore deficiencies will be cited for not being available onsite. However, here are a list of documents that we were unable to find in your facility records." This request included .. .. training for Staff B. On .. .. approximately 1:00 PM, an interview was conducted with Staff A, during which she was asked if she could provide evidence of .. training for staff B and she indicated that she provided surveyors with all the records she had. On .. .. .. at approximately 3:25 PM, an interview was conducted with Administrator in which he requested that the surveyor send him an email with documentation of training that was missing from personnel records. This surveyor informed the Administrator that an email had already been sent at 12:50 PM, but to date had not received any information. The administrator revealed he was not able to send at the time because he was driving home from his job as a	A 090		

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A 090	Continued From page 47 teacher out of town. A review of the facility's /First Aid policy stated the following "All staff and administration must be and First Aid certified by the American Red Cross or American Association. All staff will be required to act in the even a resident needed life saving skills: however, resident who have chosen to have , shall be left alone and -1 is to be contacted immediately. If the administrator is not on the premises, contact the administrator following 911." There was not a policy found during the facility record review. At the time of exit on at approximately 5:10 PM, the Administrator had not sent any of the requested records to the surveyors. Class III	A 090		
A 093 SS=F	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	A 093		

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A 093	Continued From page 48 %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 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	A 093		

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A 093	Continued From page 49 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 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	A 093		

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A 093	Continued From page 50 . . . 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 plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to plan and post menus at least 1 week in advance in an area that is accessible to 5 of the 5 residents residing at the facility. The facility also failed to maintain records of meals served at facility for the previous 6 months. The facility further failed to maintain an adequate 3-day supply of non-perishable food based on the resident census. The findings include: On at approximately 10:30 AM, an interview was conducted with resident #5. He was asked if the menus were posted in advance. Resident #5 stated " they never tell us what we are going to eat until right before time to eat. I keep cans of extra food in my room in case I don't like the food. They do have other food they will make us if we want." On . . . . . at approximately 11:00 AM, an interview was conducted with resident #1. He was asked if the menus were posted in advance. Resident #1 said: "the food is prepared; kind of off the cuff. They don't let us know in advance. They have tried the menu thing; but it does not work. They let us know what they are going to cook right before she cooks. If we don't like it. We	A 093		

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A 093	Continued From page 51 tell her we want something from the alternate menu." On at approximately 12:00 PM, an interview was conducted with Staff Member A. She was asked to describe the process for posting menus and the location where the menus are posted. Staff Member A explained that menus are not posted presently and have not been posted for the past one to two months. She said the administrator took them for revision. Staff was asked to provide copies of the most recent menus. She handed the surveyor menus that were from the year 2015. Staff Member went on to explain the process: "Normally we let the residents know what we will prepare shortly before we cook. If they do not like the option, the alternate menu is always posted in the kitchen on the board for the residents to choose from." Staff member A was asked if any of the residents were on special diets. She said "No, they are all on regular diets." She was asked how portion size is determined when serving the residents. Staff Member A explained that they do not measure portion sizes for the residents when serving. She further explained that residents are allowed to get more food whenever they desire. Staff Member A was asked to show the emergency food supply. The emergency food supply consisted of 8- 15 oz bags of raisins, 24- 1-, bags of dried plums, , of mashed potato flakes, 48 individual packs of ramen noodles. Staff Member A was asked if there was any additional food that is to be used for emergency resources. She replied this is the emergency food supply. Staff member A was asked to provide the most recent emergency food supply list and emergency menus. Staff Member A was asked if the emergency food supply looked adequate to feed 5 residents and staff members for three days.	A 093		

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A 093	Continued From page 52 She explained that they would go to the store to purchase more food if an event were pending. On a review of the most recent disaster menu and disaster food supply list was conducted. The Disaster Food Supply list and menu had an effective date of . . . . . and an expiration date of . The Disaster Food Supply list states there will be enough food for 8 residents and employees for 3 days. Food items on the list include assorted fruit juices 192 ounces (oz), assorted dry cereals 24 oz, milk(dry, boxed, evaporated) 384 oz, chicken noodle soup 64 oz, vegetable soup 64 oz, cream of mushroom soup 64 oz, canned chicken or canned meat 24 oz, canned tuna or any fish 24 oz, assorted canned meat pasta 64 oz, chili with beef 64 oz, beef stew or chicken and dumplings 64 oz, peanut butter 24 oz, jelly 24 oz, green beans 96 oz, mixed vegetables 96 oz, carrots 96 oz, peaches 32 oz, pears 32 oz, applesauce 64 oz, fruit cocktail 32 oz, pineapple 32 oz, pudding 96 oz, graham crackers or cookies 72, crackers 288, paper plates bowls and cups 96 each, plastic forks, knives, and spoons 96 each, water 24 gallons. On at approximately 3:25 PM, a telephone interview was conducted with the Administrator regarding the facility emergency food supply. He was informed that there were only a few items observed to be in the facility's emergency supply and the additional food included was not enough for a 3-day supply for 5 residents and staff. The Administrator stated he had no answer for why there was no food supply but that he would restock the emergency supply. Class III	A 093		

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	AL11967024	A. BUILDING: _____ B. WING _____	09/28/2021

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A 160	Continued From page 53	A 160		
A 160 SS=F	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 ; 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 . (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,	A 160		

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A 160	Continued From page 54 with documentation of review and approval by the county emergency management agency, as 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	A 160		

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A 160	Continued From page 55 and moratoriums issued by the agency within the last 5 years. (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, staff interview and interview with the local fire department, the facility failed to maintain a fire safety inspection by the local authority having jurisdiction or the State Fire Marshal issued within the last 2 years. The findings include: On . . . . at approximately 2:00 PM, Staff A was asked to provide a copy of the most recent fire inspection. A review of the fire inspection form provided by Staff Member A revealed the most recent fire inspection was completed . . . . . . On . . . . . at approximately 2:45 PM, the Local Fire Department having jurisdiction was telephoned to verify the date of the last fire inspection. A telephone interview was conducted with the Staff Captain/Inspector Supervisor who confirmed as the last fire inspection. She revealed the facility was currently out of compliance with the time frame for their fire inspection. She stated it was up to the facility to contact the fire department to schedule a fire inspection in a timely manner in order to maintain compliance but confirmed the facility had not at	A 160		

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A 160	Continued From page 56 the time of the interview requested their inspection. The Staff Captain/Inspector Supervisor stated she would email her copy of the report for surveyors. On at approximately 3:25 PM, a telephone interview was conducted with the administrator to request the facility most recent fire safety inspection. The administrator was informed that according to the local fire inspector the facility had not had a fire inspection since and the facility was considered to be out of compliance at the time of the interview. The administrator confirmed he had not called to set up his fire inspection. Class III	A 160		
A 200 SS=I	59A-36.025 FAC Emergency Environmental Control 59A-36.025 Emergency Environmental Control for Assisted Living Facilities. (1) DETAILED EMERGENCY ENVIRONMENTAL CONTROL PLAN. Each assisted living facility shall prepare a detailed plan ("plan") to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency environmental control in the event of the loss of primary electrical power in that assisted living facility which includes the following information: (a) The acquisition of a sufficient alternate power source such as a generator(s), maintained at the assisted living facility, to ensure that current licensees of assisted living facilities will be equipped to ensure air temperatures will be maintained at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power.	A 200		

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A 200	Continued From page 57 1. The required temperature must be maintained in an area or areas, determined by the assisted living facility, of sufficient size to maintain residents safely at all times and that is appropriate for resident care needs and life safety requirements. For planning purposes, no less than twenty (20) net square . . . per resident must be provided. The assisted living facility may use eighty percent (80%) of its licensed bed capacity as the number of residents to be used in the . . . . . to determine the required square footage. This may include areas that are less than the entire assisted living facility if the assisted living facility's comprehensive emergency management plan includes allowing a resident to congregate when he or she desires in portions of the building where temperatures will be maintained and includes procedures for monitoring residents for signs of heat related injury as required by this rule. This rule does not prohibit a facility from acting as a receiving provider for evacuees when the conditions stated in section 408.821, F.S. and subsection 59A-36.019(5), F.A.C., are met. The plan shall include information regarding the area(s) within the assisted living facility where the required temperature will be maintained. 2. The alternate power source and fuel supply shall be located in an area(s) in accordance with local zoning and the Florida Building Code. 3. Each assisted living facility is unique in size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and staffing characteristics. Accordingly, this rule does not limit the types of systems or equipment that may be used to achieve . . . . temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the	A 200		

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A 200	Continued From page 58 event of the loss of primary electrical power. The plan shall include information regarding the systems and equipment that will be used by the assisted living facility and the fuel required to operate the systems and equipment. a. An assisted living facility in an evacuation zone pursuant to chapter 252, F, S. must maintain an alternative power source and fuel as required by this subsection at all times when the assisted living facility is occupied but is permitted to utilize a mobile generator(s) to enable portability if evacuation is necessary. b. Assisted living facilities located on a single campus with other facilities under common ownership, may share fuel, alternative power resources, and resident space available on the campus if such resources are sufficient to support the requirements of each facility's residents, as specified in this rule. Details regarding how resources will be shared and any necessary movement of residents must be clearly described in the emergency power plan. c. A multistory facility, whose comprehensive emergency management plan is to move residents to a higher floor during a flood or surge event, must place its alternative power source and all necessary additional equipment so it can safely operate in a location protected from flooding or storm surge damage. (b) The acquisition of sufficient fuel, and safe maintenance of that fuel at the facility, to ensure that in the event of the loss of primary electrical power there is sufficient fuel available for the alternate power source to maintain temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours after the loss of primary electrical power during a declared state of emergency. The plan must include information regarding fuel source and fuel	A 200		

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A 200	Continued From page 59 storage. 1. Facilities must store minimum amounts of fuel onsite as follows: a. A facility with a licensed capacity of 16 beds or less must store 48 hours of fuel onsite. b. A facility with a licensed capacity of 17 or more beds must store 72 hours of fuel onsite. 2. An assisted living facility located in an area in a declared state of emergency area pursuant to section 252.36, F.S. that may impact primary power delivery must secure ninety-six (96) hours of fuel. The assisted living facility may utilize portable fuel storage containers for the remaining fuel necessary for ninety-six (96) hours during the period of a declared state of emergency. 3. Piped natural gas is an allowable fuel source and meets the onsite fuel supply requirements under this rule. 4. If local ordinances or other regulations limit the amount of onsite fuel storage for the assisted living facility's location, then the assisted living facility must develop a plan that includes maximum onsite fuel storage allowable by the ordinance or regulation and a reliable method to obtain the maximum additional fuel at least 24 hours prior to depletion of onsite fuel. (c) The acquisition of services necessary to maintain, and test the equipment and its functions to ensure the safe and sufficient operation of the alternate power source maintained at the assisted living facility. (d) The acquisition and maintenance of a monoxide alarm. (2) SUBMISSION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall submit its plan to the local emergency management agency for review within 30 days of the effective date of this rule. Assisted living facility plans previously	A 200		

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A 200	Continued From page 60 submitted and approved pursuant to emergency Rule 58AER17-1 will require resubmission only if changes are made to the plan. (b) Each new assisted living facility shall submit the plan required under this rule prior to obtaining a license. (c) Each existing assisted living facility that undergoes any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of its systems or equipment affecting the facility's compliance with this rule shall amend its plan and submit it to the local emergency management agency for review and approval. (3) APPROVED PLANS. (a) Each assisted living facility must maintain a copy of its approved plan in a manner that makes the plan readily available at the licensee's physical address for review by a legally authorized entity. If the plan is maintained in an electronic format, assisted living facility staff must be readily available to access and produce the plan. For purposes of this section, "readily available" means the ability to immediately produce the plan, either in electronic or paper format, upon request. (b) Within two (2) business days of the approval of the plan from the local emergency management agency, the assisted living facility shall submit in writing proof of the approval to the Agency for Health Care Administration. (c) The assisted living facility shall submit a consumer-friendly summary of the emergency power plan to the Agency. The Agency shall post the summary and notice of the approval and implementation of the assisted living facility emergency power plans on its website within ten (10) business days of the plan's approval by the local emergency management agency and	A 200		

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A 200	Continued From page 61 update within ten (10) business days of implementation. (4) IMPLEMENTATION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall, no later than [redacted], have implemented the plan required under this rule. (b) The Agency shall allow an extension up to [redacted] to providers in compliance with paragraph (c) below and who can show delays caused by necessary construction, delivery of ordered equipment, zoning or other regulatory approval processes. Assisted living facilities shall notify the Agency that they will utilize the extension and keep the Agency apprised of progress on a quarterly basis to ensure there are no unnecessary delays. If an assisted living facility can show in its quarterly progress reports that unavoidable delays caused by necessary construction, delivery of ordered equipment, zoning or other regulatory approval processes will occur beyond the initial extension date, the assisted living facility may request a waiver pursuant to section 120.542, F.S. (c) During the extension period, an assisted living facility must make arrangements pending full implementation of its plan that provides the residents with an area or areas to congregate that meets the safe indoor air temperature requirements of subsection (1) (a) for a minimum of ninety-six (96) hours. 1. An assisted living facility not located in an evacuation zone must either have an alternative power source onsite or have a contract in place for delivery of an alternative power source and fuel when requested. Within twenty-four (24) hours of the issuance of a state of emergency for an event that may impact primary power delivery for the area of the assisted living facility, it must	A 200		

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A 200	Continued From page 62 have the alternative power source and no less than ninety-six (96) hours of fuel stored onsite. 2. An assisted living facility located in an evacuation zone pursuant to chapter 252, F.S. must either: a. Fully and safely evacuate its residents prior to the arrival of the event; or b. Have an alternative power source and no less than ninety-six (96) hours of fuel stored onsite, within twenty-four (24) hours of the issuance of a state of emergency for the area of the assisted living facility. (d) Each new assisted living facility shall implement the plan required under this rule prior to obtaining a license. (e) Existing assisted living facilities that undergo any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of the systems or equipment affecting the assisted living facility's compliance with this rule shall implement its amended plan concurrent with any such additions, modifications, alterations, refurbishment, renovations or reconstruction. (f) The Agency for Health Care Administration may request cooperation from the State Fire Marshal to conduct inspections to ensure implementation of the plan in compliance with this rule. (5) POLICIES AND PROCEDURES. (a) Each assisted living facility shall develop and implement written policies and procedures to ensure that the assisted living facility can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. The procedures shall ensure that residents do not experience complications from fluctuations in air temperatures inside	A 200		

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A 200	Continued From page 63 the facility. Procedures must address the care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury including: 1. The use of cooling devices and equipment; 2. The use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration; 3. Wellness checks by assisted living facility staff to monitor for signs of [illegible] and heat injury; and 4. A provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy. (b) Each assisted living facility shall maintain the written policies and procedures in a manner that makes them readily available at the licensee's physical address for review by a legally authorized entity. If the policies and procedures are maintained in an electronic format, assisted living facility staff must be readily available to access the policies and procedures and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce the policies and procedures, either in electronic or paper format, upon request. (c) The written policies and procedures must be readily available for inspection by each resident; each resident's legal representative, designee, surrogate, guardian, attorney in fact, or case manager; each resident's estate; and such additional parties as authorized in writing or by law. (6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this rule, the Agency for Health Care Administration may seek any remedy authorized by chapter 429, part I, or chapter 408, part II, F.S., including, but	A 200		

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A 200	Continued From page 64 not limited to, license revocation, license suspension, and the imposition of administrative fines. (7) COMPREHENSIVE EMERGENCY MANAGEMENT PLAN. (a) Assisted living facilities whose comprehensive emergency management plan is to evacuate must comply with this rule. (b) Each facility whose plan has been approved shall submit the plan as an addendum with any future submissions for approval of its comprehensive emergency management plan. (8) NOTIFICATION. (a) Within five (5) business days, each assisted living facility must notify in writing, unless permission for electronic communication has been granted, each resident and the resident's legal representative: 1. Upon submission of the plan to the local emergency management agency that the plan has been submitted for review and approval; 2. Upon final implementation of the plan by the assisted living facility. (b) Each assisted living facility must maintain a copy of each notification set forth in paragraph (a) above in a manner that makes each notification readily available at the licensee's physical address for review by a legally authorized entity. If the notifications are maintained in an electronic format, facility staff must be readily available to access and produce the notifications. For purposes of this section, "readily available" means the ability to immediately produce the notifications, either in electronic or paper format, upon request. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility (6 licensed beds) failed to store at least 48 hours of fuel onsite for the alternate	A 200		

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A 200	Continued From page 65 power source to maintain temperatures after the loss of primary electrical power. The facility failed to provide documentation of services necessary to maintain and test the generator and portable air conditioner units and ensure their safe and sufficient operation. The facility failed to train staff how to operate the facility's alternate power source (generator and portable air conditioner unit). This has the potential to affect all 5 residents that reside in the facility. The findings include: A review of the Certified Emergency Management Plan (CEMP) approval letter was conducted. The plan had been approved and was submitted to the Leon County Board of Commissioners on . The CEMP plan approval letter stated that the next plan review date would be on . A review of the CEMP plan listed the Administrator's address as to be in Pembroke Pines, Florida (467 miles and 6 hours and 37 minutes away from Tallahassee). The plan stated that the Administrator is responsible for conducting quarterly trainings for all employees regarding emergency procedures. The plan also stated that gasoline was to be stored in 5-gallon containers in a shed approximately 60 from the facility at the rear of the property. The CEMP plan also mentioned that the facility has two portable air conditioning units available to maintain required temperatures in the event of a power failure. On at approximately 12:20 PM, an interview was conducted with Staff A, medical assistant and lead staff. She was asked to accompany the surveyor to look at the emergency power source and onsite fuel storage. An observation was made of two generators that	A 200		

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A 200	Continued From page 66	A 200		

were stored in the . . . of the garage. A GP 8600 Wacker Neuson generator with a window air-conditioning unit on top of it and Briggs and Stratton 5550 watts generator was stored in the . . . of the garage. Both units were surrounded by other storage items. She was asked to explain how she would start the generator in the event of an emergency. She explained that she did not know how to start or test the generators. Staff Member A explained that if there was a power failure, she was instructed to call the Facility Administrator. He is out of town in south Florida. He would call his brother who lives locally to come start up the system. She was asked if she knew if the generators were routinely checked or if she had documentation of generator service checks. She said "no", then went on to explain that she thinks the administrator might check the generators when he comes up from south Florida. She revealed she was not aware of any records in which documentation of the generator tests were kept. Staff member A was asked to show the emergency fuel in storage. She could not locate any fuel to start the generator. She explained that the fuel may be stored in the silver shed on the property. The surveyor accompanied Staff Member A to the silver shed. The doors were observed closed and locked and staff A did not have a key to access the shed. Staff Member A was unable to access the storage area. The CEMP lists two portable window air conditioning units to cool the facility. Only 1 portable window air conditioner was observed in the garage. Staff Member A was asked if there was another air conditioner. She said she thought there was another unit but was unable to locate the additional unit in the garage. (Photographic evidence was obtained.)

On at approximately 3:25 PM, an

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A 200	Continued From page 67	A 200		

interview was conducted by telephone with the facility administrator. The administrator was asked who was responsible for testing the generator and how often this was performed. He indicated that he had tested the generator the last time he was in town and had video of his testing, approximately 2 weeks ago. He did not offer to send this information to surveyors. The administrator was asked if he had any records, he could provide to the surveyors to demonstrate compliance with generator testing and he indicated, he had not documented his testing of the generator. He was asked if the required amount of fuel was stored onsite and if so, where would surveyors locate this fuel for observation. The administrator informed it was in the silver shed out of the facility. He was informed that the lead staff A had attempted to search the shed, but it was locked, and she did not have a key to look in the shed to confirm fuel was onsite. The administrator was informed that the surveyors needed to see the generator was working, but staff A did not know how to start the generator. The administrator was also asked to explain the process that Staff Member A was to use to get the generator started. The Administrator confirmed he had not trained Staff A how to operate the generator, but if there was an emergency, he could call one of his family members which lived on the property to start the generator at his request. The Administrator was informed the surveyors needed to observe the generator running to ensure it was functioning properly. The Administrator did not provide information or contact anyone that could assist with the observation of the generator in use. The Administrator only kept insisting that "the generator works". Near the end of the phone call the administrator stated, "I guess I should give her access and train her (referring to the lead

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A 200	Continued From page 68 staff A) to operate the generator". Also, during this call, the Administrator was asked about his expired CEMP plan, and he revealed he had not submitted his plan to the local authorities as he was waiting until he submitted the facility's renewal application. However, the Administrator revealed there had been no changes to his CEMP. Class II	A 200		
AL241 SS=E	429.075( ); 59A-36.020(2) FAC LMH - Records 429.075 (3) A facility that has a limited mental health license must: (a) Have a copy of each mental health resident's community living support plan and the agreement with the mental health care services provider or provide written evidence that a request for the community living support plan and the , agreement was sent to the Medicaid managed care plan or managing entity under contract with the Department of Children and Families within 72 hours after admission. The support plan and the agreement may be combined. (b) Have documentation provided by the department that each mental health resident has been assessed and determined to be able to live in the community in an assisted living facility that has a limited mental health license or provide written evidence that a request for documentation was sent to the department within 72 hours after admission. (c) Make the community living support plan available for inspection by the resident, the resident's legal guardian or health care surrogate, and other individuals who have a lawful basis for	AL241		

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AL241	Continued From page 69 reviewing this document. (d) Assist the mental health resident in carrying out the activities identified in the resident's community living support plan. (4) A facility that has a limited mental health license may enter into a , agreement with a private mental health provider. For purposes of the limited mental health license, the private mental health provider may act as the case manager. 59A-36.020 (2) RECORDS. (a) A facility with a limited mental health license must maintain an up-to-date admission and discharge log containing the names and dates of admission and discharge for all mental health residents. The admission and discharge log required in rule 59A-36.015, F.A.C., satisfies this condition provided that all mental health residents are clearly identified. (b) Staff records must contain documentation that designated staff have completed limited mental health training as required by rule 59A-36.011, F.A.C. (c) Resident records must include: 1. Documentation, provided by a mental health care provider within 30 days of the resident's admission to the facility, that the resident is a mental health resident as defined in section 394.4574, F.S., and that the resident is receiving social security , or supplemental security income and as follows: a. An affirmative statement on the Alternate Care Certification for , ( ) form, CF-ES 1006, , which is hereby incorporated by reference and available for review at:	AL241		

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AL241	Continued From page 70 http://www.flrules.org/Gateway/reference.asp?No =Ref-03988, that the resident is receiving SSI or SSDI due to a mental . b. Written verification provided by the Social Security Administration that the resident is receiving SSI or SSDI for a mental . Such verification may be acquired from the Social Security Administration upon obtaining a release from the resident permitting the Social Security Administration to provide such information, or c. A written statement from the resident's case manager or other mental health care provider that the resident is an adult with severe and persistent mental . The case manager or other mental health care provider must consider the following minimum criteria in making that determination: (I) The resident is eligible for, is receiving, or has received mental health services within the last 5 years, or (II) The resident has been diagnosed as having a severe or persistent mental . 2. An appropriate placement assessment provided by the resident's mental health care provider within 30 days of admission to the facility that the resident has been assessed and found appropriate for residence in an assisted living facility. Such assessment must be conducted by a psychiatrist, clinical psychologist, clinical social worker, , nurse, or an individual supervised by one of these professionals. a. Any of the following documentation that contains the name of the resident and the name, signature, date, and license number, if applicable, of the person making the assessment, meets this requirement: (I) Completed Alternate Care Certification for , , ( ) form, CF-ES Form 1006,	AL241		

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AL241	Continued From page 71 (II) Discharge Statement from a state mental hospital completed no more than 90 days before admission to the assisted living facility provided it contains a statement that the individual is appropriate to live in an assisted living facility, or (III) Other signed statement that the resident has been assessed and found appropriate for residency in an assisted living facility. b. A mental health resident returning to a facility from treatment in a hospital or crisis stabilization unit will not be considered a new admission and will not require a new assessment. However, a break in a resident's residency that requires the facility to execute a new resident contract or admission agreement will be considered a new admission and the resident's mental health care provider must provide a new assessment. 3. A Community Living Support Plan. Each mental health resident and the resident's mental health case manager must, in consultation with the facility administrator, prepare a plan within 30 days of the resident's admission to the facility or within 30 days after receiving the appropriate placement assessment in paragraph (2)(c), whichever is later, that: a. Includes the specific needs of the resident that must be met in order to enable the resident to live in the assisted living facility and the community. b. Includes the clinical mental health services to be provided by the mental health care provider to help meet the resident's needs, and the frequency and duration of such services, c. Includes any other services and activities to be provided by or arranged for by the mental health care provider or mental health case manager to meet the resident's needs, and the frequency and duration of such services and activities, d. Includes the ⌄ of the facility to facilitate and assist the resident in attending	AL241		

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AL241	Continued From page 72 and arranging transportation to for the services and activities identified in the plan that have been provided or arranged for by the resident's mental health care provider or case manager, e. Includes a description of other services to be provided or arranged by the facility, f. Includes a list of factors pertinent to the care, safety, and welfare of the mental health resident and a description of the signs and symptoms to the resident that indicate the immediate need for professional mental health services, g. Is in writing and signed by the mental health resident, the resident's mental health case manager, and the assisted living facility administrator or manager and a copy placed in the resident's file. If the resident refuses to sign the plan, the resident's mental health case manager must add a statement that the resident was asked but refused to sign the plan, h. Is updated at least annually or if there is a significant change in the resident's behavioral health, i. include the Agreement described in subparagraph (2)(c)4. If included, the mental health care provider must also sign the plan; and, j. Must be available for inspection to those who have legal authority to review the document. 4. Agreement. The mental health care provider for each mental health resident and the facility administrator or designee must prepare a written statement, within 30 days of the resident's admission to the facility or receipt of the resident's appropriate placement assessment, whichever is later. The statement: a. Provides procedures and directions for accessing emergency and after-hours care for	AL241		

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AL241	Continued From page 73 the mental health resident. The provider must furnish the resident and the facility with the provider's 24-hour emergency crisis telephone number; b. Must be signed by the administrator or designee and the mental health care provider, or by a designated representative of a Medicaid prepaid health plan if the resident is on a plan and the plan provides behavioral health services in section 409.912, F.S.; c. ˛ cover all mental health residents of the facility who are clients of the same provider; and, d. ˛ be included in the Community Living Support Plan described in subparagraph (2)(c)3. 5. Missing documentation will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the appropriate party. A documented request for such missing documentation made by the facility administrator within 72 hours of the resident's admission will be considered a good faith effort. The documented request must include the name, title, and phone number of the person to whom the request was made and must be kept in the resident's file. This Statute or Rule is not met as evidenced by: Based on resident record review, personnel record review, review of the facility's admission and discharge log, and interview, the facility failed to maintain their Limited Mental Health (LMH) records to ensure required documentation pursuant to 429.075, 59A-36.020, and 59A-36.011, F.A.C. was available for review by the State Agency for 2 of 2 LMH residents. (#2 and #4) The findings include:	AL241		

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AL241	Continued From page 74 Review of the Agency's FloridaHealthFinder.gov website revealed the facility to have a Limited Mental Health specialty license. The bed types indicated 3 Optional State Supplement beds. On at 12:50 PM, an email was sent to the Administrator per his request, with of list of documents needed to complete the survey. The email read but was not limited to "At the time of your biennial licensure survey, (the Lead Staff, Staff A) was unable to provide us information and documentation. She indicated that you were out of town at the time and unable to provide the information at the time of request. She revealed you telephoned her and requested the information be sent to you by email, so that you can provide by the end of the day. Please note per the regulation, these items must be available at the time of the survey and therefore deficiencies will be cited for not being available onsite. However, here are a list of documents that we were unable to find in your facility records." This request included LMH resident names and records as well as staffing training for LMH. On at approximately 2:45 PM, Staff A was asked if the facility had any current LMH residents and she was unable to identify any residents. The surveyor explained what services LMH residents may be receiving, and she indicated residents #2 and # , be considered LMH because they had to go to a local mental health provider to obtain their medications. When asked if she could provide documentation for residents #2 and #4 pertaining to their LMH services and staff A revealed she could not. She also revealed she did not have access to LMH training records, nor did she remember taking the training. She revealed, surveyors would need to contact the Administrator for this information.	AL241		

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AL241	Continued From page 75 On at approximately 3:45 PM, a telephone interview was conducted with the Administrator to determine if the facility had any current residents receiving LMH services. The Administrator first stated there were "none", but then recanted and revealed residents #2 and #4 were LMH residents. He indicated that LMH residents could be identified in the "facility survey book" on the Admission/Discharge Log. While on the telephone with the Administrator, this surveyor reviewed the log and residents #2 and #4 were confirmed as LMH residents. The Administrator stated resident #2 "does not really have a mental illness he had a , ,". He was asked where surveyors could locate the Support Plans for both residents and if they had a Mental Health Case Manager. The administrator directed the surveyor to look in the resident record. Upon his request, this surveyor looked and located a Community Support plan for resident #4 dated . There were no current community support plans for resident #4 or resident #2. The Administrator upon request was not able to inform this surveyor if either resident (#2 or #4) had a case manager or updated plan. He revealed the residents go to a local mental health provider 3 to 4 times a year to get medications refilled. When asked if the residents received , , ( ), the Administrator was not able to tell the surveyor if the residents were receiving , and when asked he did not provide an answer only restating what had already previously been stated. Further review of the facility's Admission/Discharge Log revealed resident #2 was admitted to the facility on from a local mental health provider. According to the log, resident #4 was admitted from a local	AL241		

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AL241	Continued From page 76 mental health provider as well. A clinical record review was conducted for resident # 2 and revealed discharge documentation dated from a local , Hospital which revealed the resident to have a primary diagnosis of and , unspecified. The record also included a copy of a Preadmission Screening and Resident Review (PASARR) Level I form. A Level I PASRR screen identifies whether an individual applying for admission into a Nursing Facility (NF) has or is suspected of having a serious mental health (SMI), intellectual , or related conditions (ID), or both. The Level I PASRR revealed resident #2 to have a mental health diagnosis of and adjustment , There was no ID diagnosis. Other related condition listed was , , , . There was no documentation from a mental health care provider found in the resident's record. There was a Medicaid card in the resident's record, but there was no evidence a Community Support Plan or any information required for residents receiving LMH services as pursuant to 429.075, 59A-36.020, and 59A-36.011, F.A.C. A clinical record review was conducted for resident #4 and revealed an Agency for Health Care Administration (AHCA) Form 1823. Form 1823 is published by The Agency for Health Care Administration, the government entity that regulates assisted living communities. Form 1823, otherwise known as the Resident Health Assessment for Assisted Living Facilities, is used to establish eligibility for assisted living services. On page 4 of 5 of the Form 1823, the date of examination was . Listed diagnosis were , , and . Also in the	AL241		

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AL241	Continued From page 77 clinical record was a Resident Demographic Information sheet, which listed the resident to have the following diagnosis: Type II . . . . . , , , and High . The Community Support plan for resident #4 dated revealed the facility was responsible for assisting the resident in attending , , and activities to medication management once a month and case management twice a month. The plan listed a telephone number for a case manager. Attempts to reach the case manager on were unsuccessful. The clinical record indicated resident # 4 to have Medicare and Medicaid. Aside from previous information stated, the facility was unable to provide documentation required for residents receiving LMH services as pursuant to 429.075, 59A-36.020, and 59A-36.011, F.A.C. At the time of exit on at approximately 5:10 PM, the Administrator had not sent any of the requested records to the surveyors. Additional documentation gathering was collected on . . . . . from the Agency's Medicaid Unit which revealed, both residents #2 and #4 received benefits. Resident #2 received $130.00 and resident #4 received $771.00. Class III	AL241		
AL243 SS=E	429.075(1) FS; 59A-36.011(9) FAC LMH - Training 429.075 (1) To obtain a limited mental health license, a facility must hold a standard license as an assisted living facility, must not have any current uncorrected violations, and must ensure that,	AL243		

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AL243	Continued From page 78 within 6 months after receiving a limited mental health license, the facility administrator and the staff of the facility who are in direct contact with mental health residents must complete training of no less than 6 hours related to their duties. This designation may be made at the time of initial licensure or relicensure or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with this part, part II of chapter 408, and applicable rules. This training must be provided by or approved by the Department of Children and Families. 59A-36.011 (9) LIMITED MENTAL HEALTH TRAINING. (a) Pursuant to section 429.075, F.S., the administrator, managers and staff, who have direct contact with mental health residents in a licensed limited mental health facility, must receive the following training: 1. A minimum of 6 hours of specialized training in working with individuals with mental health diagnoses. a. The training must be provided or approved by the Department of Children and Families and must be taken within 6 months of the facility's receiving a limited mental health license or within 6 months of employment in a limited mental health facility. b. Training received under this subparagraph may count once for 6 of the 12 hours of continuing education required for administrators and managers pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 2. A minimum of 3 hours of continuing education, which may be provided by the ALF administrator, online, or through distance learning, biennially thereafter in subjects dealing with one or more of	AL243		

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	AL11967024	A. BUILDING: _____ B. WING _____	09/28/2021

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AL243	Continued From page 79 the following topics: a. Mental health diagnoses; and, b. Mental health treatment such as: (I) Mental health needs, services, behaviors and appropriate interventions; (II) Resident progress in achieving treatment goals; (III) How to recognize changes in the resident's status or condition that may affect other services received or may require intervention; and, ( ) Crisis services and the . . . . . procedures. 3. For administrators and managers, the continuing education requirement under this subsection will satisfy 3 of the 12 hours of continuing education required biennially pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 4. Administrators, managers and direct contact staff affected by the continuing education requirement under this subsection shall have up to 6 months after the effective date of this rule to meet the training requirement. (b) Administrators, managers and staff do not have to repeat the initial training should they change employers provided they present a copy of their training certificate to the current employer for retention in the facility's personnel files. They must also ensure that copies of the continuing education training certificates, pursuant to subparagraph (a)2. of this subsection, are retained in their personnel files. This Statute or Rule is not met as evidenced by: Based on resident record review, personnel record review, review of the facility's admission and discharge log, and staff interview, the facility failed to ensure at least 6 hours of Limited Mental Health (LMH) training related for their duties for 3	AL243		

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AL243	Continued From page 80 of 3 employees that have been employed with the facility for 6 months of more. (Administrator, Staff A, and Staff B) The findings include: On . . . at 11:22 AM, a request was made for personnel records for Staff A-E from staff A, medical assistant and lead staff. Staff A provided the surveyor personnel records for 3 staff to include herself, staff B and Staff C. Staff A stated she had called the administrator and he informed her to ask that surveyors to send him an email of any documents that were needed and he would send by the end of the day. Record review of all personnel records revealed the following: The Administrator's personnel record was not available at the time of the survey. Staff A, medical assistant and lead staff, had a date of rehire as . . . . Staff A's primary shift was 7 AM to 3 PM, Monday through Friday and any time staff were not able to work. There was no documentation of LMH training. Staff B, direct care, had a date of hire of . Staff B's primary shift was 8 PM to 7 AM. Staff B's personnel record revealed there was no documentation of LMH training. On . . . . . at approximately 2:45 PM, Staff A was asked if the facility had any current LMH residents and she was unable to identify any residents. The surveyor explained what services LMH residents may be receiving, and she indicated resident #2 and # , be considered LMH because they had to go to a local mental health provider to obtain their medications. When	AL243		

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AL243	Continued From page 81 asked if she could provide documentation for residents #2 and #4 pertaining to their LMH services and staff A revealed she could not. She also revealed she did not have access to LMH training records, nor did she remember taking the training. She revealed, surveyors would need to contact the Administrator for this information. On [redacted] at approximately 3:45 PM, a telephone interview was conducted with the Administrator to determine if the facility had any current residents receiving LMH services. The Administrator first stated there were "none", but then recanted and revealed residents #2 and #4 were LMH residents. He also confirmed that staff had not been trained to include Staff A and B on LMH. Class III	AL243		
CZ813	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 and staff interview, the facility failed to maintain within their personnel records the eligibility results of employee Level II background screening for 4 of 6 staff (Administrator, Staff C, D, and E) or a signed Attestation of compliance for 5 of 6 staff reviewed (Administrator, Staff A, C, D, and E).	CZ813		

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CZ813	Continued From page 82 The findings were: On at approximately 11:22 AM, a request was made for personnel records for the Administrator and employees A-E from staff A, medical assistant and lead staff. Staff A provided personnel records for 3 staff to include herself, staff B and Staff C. She revealed she only had applications for Staff D and Staff E. Staff A stated she did not have access to the Administrator's personnel record and copies would need to be obtained directly from him. Staff A stated she had telephoned the administrator and he informed her to ask that surveyors send him an email with a list of any documents that were needed, and he would send them by the end of the day. A review of the personnel records was conducted and revealed that copies of the Level II background screening and signed Attestation of compliance forms were not in the personnel records of several staff. Staff A, medical assistant and lead staff, had a date of rehire as . Staff A's personnel record revealed there to be an unsigned and undated Attestation form in the staff's record. Staff C, direct care staff, had a date of hire of . Staff C's personnel record revealed there was no eligibility results of a Level II background Screening or Attestation form. Staff D, direct care staff, had a date of rehire as . Staff D's personnel record revealed there was no eligibility results of a Level II background Screening or Attestation form. Staff E, direct care staff, had a date of rehire as . Staff E's personnel record revealed there was no eligibility results of a Level II background Screening or Attestation form.	CZ813		

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CZ813	Continued From page 83 The Administrator's personnel record was not available at the time of the survey. On at approximately 11:55 AM, a follow-up interview was conducted with Staff A, medical assistant and lead staff, and she confirmed she did not have any additional staff records to provide but had informed the administrator via a text message that several personnel records were missing. On at 12:50 PM, an email was sent to the Administrator per his request with a list of documents needed to complete the survey. On at approximately 3:25 PM, a telephone interview was conducted with the Administrator on the facility's telephone. The Administrator was informed that the personnel records for Staff C, D, and E did not have results of a Level II background Screening or Attestation forms. The Administrator revealed, he had not completed this task, but knew all 3 staff were eligible because they worked for other providers prior to being hired with the facility. When asked if Staff A could access these records, he indicated she did not have access. He was also informed that the Attestation for Staff A's personnel record was not signed and dated, and the Administrator stated, "I guess she forgot to sign. I'll make sure this is done". The administrator did not offer to provide his personnel file upon request. On a review was conducted of the Agency for Health Care Administration's Background Screening website which revealed the administrator, staff C, D, and E all had eligible background screenings, however the information was not available in the employee records.	CZ813		

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CZ813	Continued From page 84 At the time of exit on [redacted] at approximately 5:10 PM, the Administrator had not provided any of the requested records. Unclassified	CZ813		
CZ814	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 individual taxpayer identification number.	CZ814		

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CZ814	Continued From page 85 This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interview, the facility failed to maintain the employment status of all employees within the clearinghouse within 10 business days for 5 of 9 staff reviewed (A, B, F, G, and H). The findings were: On at 12:52 PM, a request was made for a copy of the facility's clearinghouse roster from staff A, medical assistant and lead staff. Staff A revealed she does not have access to background screenings or clearinghouse roster. She confirmed she was in charge in the absence of the administrator and stated, "it would be good to know where this stuff is located, so I could provide upon request." She confirmed the facility to have 5 employees to including herself (A, B, C, D, E). On at approximately 3:25 PM, a request was made for the facility clearing house roster during a telephone interview with the Administrator and he stated, "it not up to date, but I will get it updated today". A copy was not provided, and he confirmed Staff A did not have access to provide surveyors a copy of the clearinghouse roster. On . . . at approximately 4:30 PM, the clearinghouse roster was reviewed on the Agency for Health Care Administration's Background Screening website. The roster revealed the following: Staff A, medical assistant and lead staff, had been removed from the roster on with an initial hire date of . The roster had not been updated to add staff A to the roster	CZ814		

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CZ814	Continued From page 86 since being rehired on . Staff B, direct care, was not listed on the roster. His date of hire was . Further review revealed there to be 3 additional employees (F, G, H) whose status was not current. Staff F, G, and H were confirmed by Staff A at the time of the review to no longer be employees at the facility and that it had been greater than 10 business days since they had left their positions. Unclassified	CZ814		
CZ816	408.809(2) 435.05(2) 59A-35.090(2d-3b) Background Screening-Compliance Attestation 408.809 Background screening; prohibited offenses.- (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's , to the Federal Bureau of Investigation for a national criminal history record check unless the person's , , are enrolled in the Federal Bureau of Investigation's national retained print notification program. If the , , of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit , , electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward	CZ816		

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CZ816	Continued From page 87 the [illegible] to the Federal Bureau of Investigation for a national criminal history record check. The [illegible] shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person [illegible]. The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that: (a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section; (b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and (c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency. 435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers: (2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this	CZ816		

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CZ816	Continued From page 88 chapter and agreeing to inform the employer immediately if for any of the disqualifying offenses while employed by the employer. 59A-35.090 Background Screening. (2) Processing Screening Requests, Required Documents and Fees. (d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, , herein incorporated by reference, available at http://www.flrules.org/Gateway/reference.asp?No =Ref-09106, and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Service s/Background_Screening/Regulations_Forms.sht ml. This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if for any disqualifying offense. (e) An administrator or chief financial officer must be screened and qualified prior to , , to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the report and court	CZ816		

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CZ816	Continued From page 89 disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to Section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with Section 435.06(3), F.S. This Statute or Rule is not met as evidenced by: Based on personnel record review and staff interview, the facility failed to ensure every employee completed an Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008 for 4 of 6 employees reviewed (Administrator, Staff C, D, and E). The finding include: On at approximately 11:22 AM, a request was made for personnel records for the Administrator and employees A-E from staff A, medical assistant and lead staff. Staff A provided personnel records for 3 staff to include herself, staff B and Staff C. She revealed she only had applications for Staff D and Staff E. Staff A stated she did not have access to the Administrator's personnel record, and it would need to be obtained directly from him but verified he lived out of town. Staff A further stated she had called the administrator and he had informed her to ask that surveyors to send him an email of any documents that were needed and he would send by the end of the day. A review was conducted of the personnel records which failed to reveal Attestation forms for several staff.	CZ816		

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CZ816	Continued From page 90 Staff C, direct care staff, had a date of hire of . . . . Staff C's personnel record revealed there was no Attestation form. Staff D, direct care staff, had a date of rehire as . Staff D's personnel record revealed there was no Attestation form. Staff E, direct care staff, had a date of rehire as . . . . . Staff E's personnel record revealed there was no Attestation form. The Administrator's personnel record was not available at the time of the survey. On at approximately 11:55am, a follow-up interview was conducted with Staff A, medical assistant and lead staff, and she confirmed she did not have any additional staff records to provide but stated she had notified the administrator via a text message that several personnel records was missing. On at 12:50 PM, an email was sent to the Administrator per his request with a list of documents needed to complete the survey to include copies of the signed attestation of compliance forms. On at approximately 3:25 PM, a telephone interview was conducted with the Administrator on the facility's telephone. The Administrator was informed that the personnel records for Staff C, D, and E did not have Attestation forms. The Administrator revealed, he had not completed this task, but knew all 3 staff were eligible because they worked for other providers prior to being hired with the facility. When asked if Staff A could access these records, he indicated she did not access to do so. The administrator did not offer to provide his personnel file upon request.	CZ816		

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CZ816	Continued From page 91 At the time of exit on at approximately 5:10 PM, the Administrator had not sent any of the requested records to the surveyors. Unclassified	CZ816		
CZ830 SS=D	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status,	CZ830		

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LA GRANDE BELLE	5898 ORCHARD POND ROAD TALLAHASSEE, FL 32303

(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
CZ830	Continued From page 92 each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be	CZ830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CZ830	Continued From page 93 prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based upon staff interview and review of the facility's Comprehensive Emergency Management Plan (CEMP), the facility failed to resubmit the CEMP plan for review and approval as requested by the local Emergency Management Agency. The findings include: A review of the CEMP plan approval letter was conducted. The plan had been approved and was submitted to the Leon County Board of Commissioners on . . . . . The CEMP plan approval letter stated that the next plan review date would be on . . . . . . On . . . . . at 12:50pm, an email was sent to the Administrator per his request of information that was missing. The email read but was not limited to "At the time of your biennial licensure survey, the Lead Staff, Staff A was unable to provide us information and documentation. She indicated that you were out of town at the time and unable to provide the information at the time of request. She revealed you telephoned her and requested the information be sent to you by email, so that	CZ830		

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CZ830	Continued From page 94 you can provide by the end of the day. Please note per the regulation, these items must be available at the time of the survey and therefore deficiencies will be cited for not being available onsite. However, here are a list of documents that we were unable to find in your facility records." A request was included in this email for the facility's updated CEMP approval. On 3:25 PM, during a phone interview with the Administrator, a request was made for an updated CEMP plan approval letter from Leon County Board of Commissioners. He was informed that the current plan had a date of [redacted] and asked if he had submitted and updated plan since this expiration and he confirmed he had not submitted a plan since the plan reviewed by surveyors. He indicated there have been no changes, and so he was waiting until he submitted his renewal application. He stated, "I guess I'll take the citation for this". Class III	CZ830		