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
	AL11965768	A. BUILDING: _____ B. WING _____	02/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THORNTON GARDENS	618 E CENTRAL BLVD. ORLANDO, FL 32821

(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 Complaint Investigation #2022001871 was conducted from [redacted] to [redacted]. Thornton Gardens had defciencies found at the time of the visit. The facility failed to protect residents from unsafe conditions, placed the residents at risk of living in an environment ill-equipped to provide for resident health, safety and welfare due to lack of supervision and care, and placed residents in a facility where residents' safety and protection were overlooked. These failures posed an immediate and serious danger to the public health, safety, and welfare of all the residents in the facility. As a result of these failures, resident #2 sustained [redacted] injuries and [redacted] at the facility.	A 000		
A 025 SS=J	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. 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 [redacted] 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	A 025		

AHCA Form 3020-0001

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

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A 025	Continued From page 1 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 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 interviews, the facility failed to provide adequate supervision for a resident who was placed alone	A 025		

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A 025	Continued From page 2 in a wheelchair lift and sent the lift to the second floor without staff inside accompanying the resident who was diagnosed with . . . . . (#2). Findings: On . . . . . at 4:49 PM, the facility administrator filed an electronic incident report with the Agency for Health Care Administration (AHCA), which reflected that resident #1 while using the facility's wheelchair lift on . The administrator noted on the incident report that she was told during a telephone call with caregiver C that, "Resident hit her . . . in the lift and has . . . . . ." The administrator stated the incident happened around 7:50 PM and she was called by caregiver C at 7:57 PM. On at 10 AM, the administrator stated the information provided in the electronic incident report was correct and accurate. The administrator stated the wheelchair lift was installed in the building 20 years ago and she was told it did not require licensing by the state. The administrator stated the wheelchair lift did not have operating instructions; it is a push button system. The administrator stated the wheelchair lift does not have a maintenance or service plan and a local company provides service when she needs them to come out. The administrator further stated caregiver C was the staff involved in the incident and she was on the schedule working today, . On at 11:05 AM, the operation of the wheelchair lift was observed. The lift ran between the first and second floor. The opening door on the first and second floor would not open unless the wheelchair lift is at that level. Staff and	A 025		

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A 025	Continued From page 3 residents can push the button on the wall outside of the lift to call the wheelchair lift to their location. The wheelchair lift has buttons that control the same operation along with a button taped over which read, "Do not push". The second-floor landing is observed to have a three-inch gap between the lift and the second-floor landing. If the lift is at the first-floor landing, when pushed up, it passes the top of the first-floor door jam which is an estimated 6-inchs, from the of the door to the edge of the wheelchair lift creating an area if something is caught would be crushed. Photographic evidence was obtained. On at 11:20 AM, caregiver C stated she would not provide a statement to the agency and that the agency staff should contact her attorney. Resident #1's record reflected that that resident had a diagnosis of and was a high risk. On at 2:20 PM, caregiver D said she worked the schedule prior to the incident, ending at 7 PM on . She stated resident #1 was seated downstairs in her wheelchair and was calm. She stated when resident #1 would get upset, she would rock and forth in her wheelchair. She said she was told to ride the lift with the residents, but she has observed that caregiver C does not follow this practice. On at 3 PM, the administrator stated she did not have a written policy regarding the usage of the wheelchair lift; training with staff was all verbal. She stated the staff schedule she provided to the agency was correct, that caregiver C was scheduled to work on from 7 PM to 7 AM and was the only staff on-duty at the	A 025		

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A 025	Continued From page 4 time of the incident. It was accurate in showing caregiver C scheduled to work: , , and . On at 3:25 PM, the Nurse Practitioner for resident #1 stated the resident had . She stated resident #1 would not have the ability, based on her diagnosis, to run the wheelchair lift alone. On at 5:15 PM, the administrator stated she had not gotten a statement from caregiver C, despite working with her on and . She stated her internal investigation was what she had provided to AHCA in the electronic incident report; she had not done anything else. Review of the electronic incident report written by the administrator, indicated she had the opportunity to speak with caregiver C on at 10:52 PM, the night of the incident with resident #1. On at 5:15 PM, the administrator stated she felt comfortable having caregiver C work because other workers were around. The administrator agreed to remove caregiver C from the work schedule after a lengthy discussion concerning risk factors with the AHCA representatives. On at 8:58 AM, caregiver G stated she has not been trained regarding emergencies or emergency preparedness. She stated no one taught her how to load a resident onto the wheelchair lift, but she knows, "she could not put a resident in the lift alone". She stated resident #1 liked to push in her wheelchair.	A 025		

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A 025	Continued From page 5 When asked about not riding the lift with the resident, she stated, "Why would you do that? They might get upset." On ..... at 10:05 AM, the administrator reconfirmed she did not have a written policy on staff usage and operation of the wheelchair lift. She provided a guideline for staff on operating the wheelchair lift on ..... but had not reviewed the guideline with caregiver C despite caregiver C having worked at the facility on and . On at 11:47 AM, the administrator stated she felt caregiver C was not in the wheelchair lift. When asked why, she stated, "Caregiver C had called her from the facility house telephone, and she would not have had access to that if she was in the wheelchair lift." On ..... at 12:59 PM, caregiver E stated she knew resident #1 and stated resident #1 would push ... on her wheelchair and push it backwards. On at 1 PM, as shown by the administrator, a hole on the top of the door leading to the lift on the second floor was observed. A screwdriver or other similar tool can be put inside the hole to unlock the door in an emergency. The administrator stated she could not recall whether she trained caregiver C on this procedure. On ..... at 4:21 PM, caregiver F stated she was not taught how to operate the wheelchair lift. She stated that it is, "Pretty much common sense; you ride the lift with the resident." Review of the AHCA 1823 Health Assessments	A 025		

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A 025	Continued From page 6 reflected the following: Resident #2 - diagnosis of . (1823 signed) Resident #3 - diagnosis of . (1823 signed) Resident #4 - diagnosis of bi-polar. Resident #5 - diagnosis of memory loss.(1823 signed) Resident #6 - diagnosis of . Resident #7 - diagnosis of and currently working with Hospice Resident #8 - diagnosis of . (1823 signed) On at 11:40 AM, resident #3 was not able to provide the year, did not remember the names of staff, and did not know the name of the current president. She was seen ambulating with a cane. On at 11:45 AM, resident #6 was seated in a recliner in her room on the second floor. She was not able to provide the names of her caregivers. She requires use of the wheelchair lift. On at 11:50 AM, resident #8 stated she did not have breakfast despite having breakfast, did not know the name of the administrator, calling the administrator by the name of her daughter-in-law. She ambulates with a walker and uses the wheelchair lift. On at 11:55 AM, resident #7 was seated in a recliner. She was unable to answer any questions. The resident uses a wheelchair, lives on the second floor and uses the wheelchair lift. On at 11:59 AM, resident #4 stated she	A 025		

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A 025	Continued From page 7 uses uses a walker, and required the use of the wheelchair lift. She did know the name of the administrator and what she had for breakfast. On . . . . . at 1:30 PM, a local Law Enforcement Detective confirmed the following: "[name of resident #1] was a . . . . . adult due to suffering from / . . and being immobile. She was reliant on nurses and other staff at the Assisted Living Facility for her care and protection. [Name of resident #1] was placed in a hydraulic lift/elevator system at the Assisted Living Facility . . . She was placed there by her nurse to be transported from the first floor to the second floor. The lift was sent upward and during the ascent, the handle of the wheelchair that [name of resident #1] was seated in hit the , of the first-floor door jam, causing it to lean backwards and eventually tilt over backward. This caused [name of resident #1] to land on her as the lift continued to rise. Eventually, [name of resident #1's] was crushed by the second-floor landing and . . . because of her injuries." On at 2:30 PM, a State of Florida Elevator Inspector saw the wheelchair lift. He stated he could not inspect the unit because it is required to have a state license, and the lift did not have a license. He stated it could not be licensed because of the concerns of the gaps in the two door jams, and the top of the first-floor door jam. On . . . . . at 2:30 PM, the State of Florida Elevator Inspector placed a "Sealed for your safety, do not use" sticker on the doors of the lift on the first and second floor. The facility failed to provide adequate supervision	A 025		

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A 025	Continued From page 8 to a resident diagnosed with . . . . . by putting her in a wheelchair lift by herself to go to the second floor. There was no investigation conducted and statements obtained to determine what occurred on the day of the incident. Caregiver C was allowed to continue to work with the other residents on . . . . . and . . . . . , placing the remaining residents at risk. There were no policies and procedures and training documented before the day of the incident, ... Class I	A 025		
A 077 SS=J	429.176 FS; 429.52(.),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who 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.	A 077		

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A 077	Continued From page 9 Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least [illegible]; 2. If employed on or after [illegible], have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to [illegible], 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,	A 077		

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A 077	Continued From page 10	A 077		

such as the . . . . of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must:
1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and,
2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility.
(c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile . . . . of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities.
(d) An individual serving as a manager must 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

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A 077	Continued From page 11 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 record review and interviews, an immediate threat to the safety of the resident community was reflected through a lack of training, written policy, and internal investigation, based on the resident diagnosis and ability of the 8 residents. Findings: On at 4:49 PM, the facility administrator filed an electronic incident report with the Agency for Health Care Administration (AHCA), which reflected that resident #1 while using the facility's wheelchair lift on . The administrator noted on the incident report that she was told during a telephone call with caregiver C that, "Resident hit her in the lift and has ." The administrator stated the incident happened around 7:50 PM and she was called by caregiver C at 7:57 PM. On at 10 AM, the administrator stated the information provided in the electronic incident report was correct and accurate. The administrator stated the wheelchair lift was	A 077		

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A 077	Continued From page 13 On . . . . . at 3:25 PM, the Nurse Practitioner for resident #1 stated the resident had . She stated resident #1 would not have the ability, based on her diagnosis, to run the wheelchair lift alone. On . . . . . at 5:15 PM, the administrator stated she felt comfortable having caregiver C work because other workers were around. The administrator agreed to remove caregiver C from the work schedule after a lengthy discussion concerning risk factors with the AHCA representatives. Review of the electronic incident report, written by the administrator, indicated she had the opportunity to speak with caregiver C on at 10:52 PM, the night of the incident with resident #1. On . . . . . at 8:58 AM, caregiver G stated she has not been trained regarding emergencies or emergency preparedness. She stated no one taught her how to load a resident onto the wheelchair lift, but she knows, "She could not put a resident in the lift alone." She stated resident #1 liked to push in her wheelchair. When asked about not riding the lift with the resident, she stated, "Why would you do that? They might get upset." On at 10:05 AM, the administrator reconfirmed she did not have a written policy on staff usage and operation of the wheelchair lift. She provided a guideline for staff on operating the wheelchair lift on but had not reviewed the guideline with caregiver C despite caregiver C having worked at the facility on . . . . . and	A 077		

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	AL11965768	A. BUILDING: _____ B. WING _____	02/11/2022

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A 077	Continued From page 14 On . . . . . at 12:59 PM, caregiver E stated she knew resident #1 and stated resident #1 would push . . . on her wheelchair and push it backwards. On at 4:21 PM, caregiver F stated she was not taught how to operate the wheelchair lift. She stated that it is, "Pretty much common sense; you ride the lift with the resident." Review of the AHCA 1823 Health Assessments reflected the following: DATE of ASSESSMENTS??? Resident #2 - diagnosis of . Resident #3 - diagnosis of . . . . . . Resident #4 - diagnosis of bi-polar. Resident #5 - diagnosis of memory loss. Resident #6 - diagnosis of . Resident #7 - diagnosis of . . . . . and currently working with Hospice Resident #8 - diagnosis of . . . . . . On . . . . . at 11:45 AM, resident #3 was not able to provide the year, did not remember the names of staff and the name of the current president. The resident ambulates with a cane. On at 11:45 AM, resident #6 sat in a recliner in her room on the second floor. She was not able to provide the names of her caregivers. She required use of the wheelchair lift. On . . . . . at 11:50 AM, resident #8 stated she did not have breakfast despite having breakfast, did not know the name of the administrator, calling the administrator by the name of her daughter-in-law. She ambulates with a walker and uses the wheelchair lift. On at 11:50 AM, resident #7 sat in a	A 077		

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A 077	Continued From page 15 recliner. She was unable to answer any questions. The resident used a wheelchair, lived on the second floor and used the wheelchair lift. On [redacted] at 11:55 AM, resident #4 stated she used a walker, and required the use of the wheelchair lift. She did know the name of the administrator and what she had for breakfast. The administrator did not conduct an investigation of the incident that occurred on [redacted]. There were no statements obtained from the staff that was onsite and was working with resident #1 at the time of the incident. The administrator did not protect the residents and allowed caregiver C to continue to work in the facility with the remaining residents, until it was brought to her attention by the AHCA representatives. This caregiver was allowed to remain in the facility working with the residents and the administrator did not attempt to obtain a statement from caregiver C and provide additional training to caregiver C. Class I	A 077		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee	A 081		

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A 081	Continued From page 16 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 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,	A 081		

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A 081	Continued From page 17	A 081		

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:
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

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A 081	Continued From page 18 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 record reviews and interviews, the facility failed to ensure 1 of 3 caregivers failed to provide documentation of having completed pre-service orientation (E). Findings: Caregiver E's personnel record revealed a date of hire of [redacted]. The personnel record did not include documentation of having completed the required pre-service orientation. On [redacted], review of the facility background screening roster listed the dates of hire for caregiver E as [redacted]. On [redacted] at 3 PM, after reviewing the employee file, the administrator was unable to	A 081		

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A 081	Continued From page 19 provide documentation that caregiver E completed the required pre-service orientation. Class III	A 081		
A 152 SS=J	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during	A 152		

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A 152	Continued From page 20	A 152		

use.
(e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be .

This Statute or Rule is not met as evidenced by:
Based on interviews and observations, the facility placed the resident community in immediate harm by failing to maintain a safe living environment free of hazards and failing to ensure all mechanical devices are maintained in good working order, properly licensed and inspected.

Findings:

On at 4:49 PM, the facility filed an electronic incident report with the Agency for Health Care Administration, written by the facility administrator, documenting Resident #1 while using the facility wheelchair lift. The incident report documented she was told during a telephone call with Staff C, that, "Resident hit her in the lift and had ,". The administrator stated the incident happened around 7:50 PM and she was called by Staff C at 7:57 PM.

On at 10 AM, the administrator stated the wheelchair lift was installed in the building 20 years ago and she was told it did not require licensing by the State of Florida. The administrator stated the wheelchair lift did not have operating instructions; it is a push button system. The administrator stated she does not have a maintenance or service plan for the wheelchair lift, and a local company provides service when she needs them to come out.

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A 152	Continued From page 21 On . . . . . at 11:05 AM, the operation of the wheelchair lift was observed. It ran between the first and second floor. The opening door on the first and second floor would not open unless the wheelchair lift is at that level. Staff and residents can push the button on the wall outside of the lift to call the wheelchair lift to their location. The wheelchair lift had buttons that controlled the same operation along with a button taped over which read, "Do not push". On the second-floor landing was a three-inch gap between the lift and the second-floor landing. If the lift is at the first-floor landing, when pushed up, it passes the top of the first-floor door jamb which is an estimated 6-inch, "crush" point. Photographic evidence was obtained. On at 3 PM, the administrator stated she did not have a written policy regarding the usage of the wheelchair lift; training with staff was all verbal. On . . . . . at approximately 3:30 PM, a representative of a local elevator company who serviced the Whirlteq wheelchair lift stated they only provide service when the facility calls. The last call was on . . . . . and it was for lubrication of the doors and first floor door lock adjustment. The elevator dimensions are 35 inches wide and 47 inches long. On at 1:30 PM, a local law enforcement detective confirmed the following: "[Resident #1's name] was a adult due to suffering from . . . . . / . . . . . and being immobile . . . was reliant on nurses and other staff at the Assisted Living Facility for her care and protection. [Resident #1's name] was placed in a hydraulic lift/elevator system at the . . . facility. She was placed there by her nurse	A 152		

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A 152	Continued From page 22 (caregiver) to be transported from the first floor to the second floor. The lift was sent upward and during the ascent, the handle of the wheelchair that [Resident #1's name] was seated in hit the , of the first-floor door jam, causing it to lean backwards and eventually tilt over backward. This caused [Resident #1's name] to land on her . . . as the lift continued to rise. Eventually, [Resident #1's name] . . . was crushed by the second-floor landing and because of her injuries." On at 3 PM, the wheelchair lift was observed with a . , ... from the same local elevator company that serviced the lift on . . . . He showed the agency how the unit operates. He closed his report documenting, "There is a risk factor from the first-floor door frame when the unit's platform is in the up direction." On . . . . . at 2:30 PM, in observation and interview with a State of Florida elevator inspector, he documented the operation of the wheelchair lift. He stated he could not inspect the unit because it is required to have a state license. He stated it could not be licensed because of the concerns of the gaps in the two door jams, and the top of the first-floor door jam. At the conclusion on his inspection, the state elevator inspector placed a "Sealed for your safety, do not use" sticker on the doors of lift on the first and second floors. Class I	A 152		
CZ816	408.809(2) 435.05(2) 59A-35.090(2d-3b) Background Screening-Compliance Attestation 408.809 Background screening; prohibited	CZ816		

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CZ816	Continued From page 23 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 the ... to the Federal Bureau of Investigation for a national criminal history record check. The ... 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 ... 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	CZ816		

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CZ816	Continued From page 24 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 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_Services/Background_Screening/Regulations_Forms.shtml. This form must be completed by the individual	CZ816		

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CZ816	Continued From page 25 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 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 record reviews and interviews, the facility failed to ensure 1 of 3 staff (E) provided documentation of having signed the required attestation form. Findings:	CZ816		

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CZ816	Continued From page 26 Staff E's personnel record revealed the date of hire as . The personnel record did not include documentation of having signed the required attestation form. On , review of the facility background screening roster listed the date of hire for staff E as . On at 3 PM, the administrator was unable to provide the documentation staff E's signed attestation form. Unclassified	CZ816		