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
	AL11968987	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ASSISTED LIVING FACILITY, LLC	319 ELDRIDGE AVE ORANGE PARK, FL 32073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint survey (complaint numbers 2021012815, 2021015339 and 2022001684) was conducted at Vision Manor Assisted Living Facility from . . . . . to . . . . . . Deficient practice was identified, including Class I deficient practice for staffing and resident rights. .	A 000		
A 030 SS=L	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968987	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ASSISTED LIVING FACILITY, LLC	319 ELDRIDGE AVE ORANGE PARK, FL 32073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 1	A 030		

telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and ;
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and standard precautions;
8. The requirements for coordinating the delivery of services to residents by third party providers;
9. Assistive devices; and
10. Physical
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed

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
	AL11968987	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ASSISTED LIVING FACILITY, LLC	319 ELDRIDGE AVE ORANGE PARK, FL 32073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 2 capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from [redacted] and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968987	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ASSISTED LIVING FACILITY, LLC	319 ELDRIDGE AVE ORANGE PARK, FL 32073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 3 resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making . . . . . for health care services, the provision of or arrangement of transportation to health care . . . . . , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally . . . . . , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968987	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ASSISTED LIVING FACILITY, LLC	319 ELDRIDGE AVE ORANGE PARK, FL 32073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 4	A 030		

provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.
(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.
(2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968987	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ASSISTED LIVING FACILITY, LLC	319 ELDRIDGE AVE ORANGE PARK, FL 32073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 5 kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review, interview, and observation, the facility failed to ensure resident rooms and common areas were maintained in a manner that preserved residents' rights to a clean, safe, and homelike environment. The deterioration of facility grounds affected all 16	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968987	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ASSISTED LIVING FACILITY, LLC	319 ELDRIDGE AVE ORANGE PARK, FL 32073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 6 residents of the facility. The findings include: During a telephone interview on at 9:30 am, a representative from the State Fire Marshal's office stated that while conducting business at the facility, he had concerns over the lack of upkeep to the building. The building was older, and repairs were needed. The facility grounds were observed during an off-hours tour on at 1:40 am. Towards the exit of the main building, leading to the corridor with resident rooms, a red bucket was observed directly below an area with missing ceiling tiles, with wet floor signs close by. Between the main building and the building with resident rooms there was one large pool, one smaller pool, and a putting green. On the pool was observed to be nearly empty, except for about of brown water and debris within it. The exposed walls were covered in debris. Equipment was seen hanging over the side and floating within. The pool is situated in the middle of the property in a high traffic area to both residents and staff who must pass it to get to the dining room, activities center, and nurse's station. (Photographic evidence obtained) The putting green directly behind the pool was torn up and the green fabric was lying in a heap. Behind the putting green was a maintenance shed with a door hanging off its hinges. Awnings above the windows of the dining room which overlook the pool area were sun bleached and a window was cracked underneath, which was taped over. (Photographic evidence obtained) At 2:01 am on , an observation of the	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968987	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ASSISTED LIVING FACILITY, LLC	319 ELDRIDGE AVE ORANGE PARK, FL 32073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 7 second-floor water tank room found the lock outside was taped on with clear tape, and the metal bar that closed the two doors together was broken, making the room available for entry. (Photographic evidence obtained) The dining room was toured at 2:15 am on . Upon entering a high pitch whistling was heard, audible over the radio playing. The source appeared to be from a section of ceiling tile was missing, where duct work was visible. The surrounding tiles were water stained. Several AC vents in the dining room were caked with dust/debris. (Photographic evidence obtained) At 7:50 am on , Resident #3 was interviewed. He was sitting in his wheelchair in his room. He stated he had never had a housekeeper come in. He explained he had lived here several years and saw the steady decline of available staff for services such and housekeeping and maintenance. The floors of the room were covered in a layer of dirt/debris. There was no bed (which the resident confirmed was his choice) which allowed for more open area; all the floor space was covered in debris. The AC unit, attached to the lower wall just under the window that overlooked the walkway, was covered in a layer of debris and black growth on the top. Resident #3's bathroom was covered in brown debris from wall to wall. The handwashing sink was covered in a layer of debris, and he explained the handwashing faucet could be lifted right off the base. When lifted, there was debris under the rim of the faucet, and it did not appear to even be adhered on (due to a lack of any residual glue remaining). As a result, deposits of black debris were observed when the faucet was lifted. He explained when he took showers, the floor flooded so he cleaned it himself with towels,	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968987	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ASSISTED LIVING FACILITY, LLC	319 ELDRIDGE AVE ORANGE PARK, FL 32073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 8	A 030		

but he wasn't always successful. A bin of towels was observed next to the shower. It was filled with trash and caked with debris. The shower was not clean: it contained build up within the shower and its edges, and the shower curtain was soiled. A portion of the wall next to the shower was missing a section approximately 1 by 2 in length, right beside the shower and under the towel rack. Debris was observed within this hole. Resident #3 explained that when they repaired it, they used a material which then got wet (due to the location next to the shower) and it deteriorated, and the patch didn't last. (Photographic evidence obtained)

At the end of the interview, Resident #3 stated he blamed himself for the condition of the room because of his mental health issues.

Review of the 1823 Health Assessment for Resident #3 showed he required assistance with ambulation, bathing, and . He was wheelchair bound.

Resident #4 was interviewed on at 9:29 am. He explained he had been in this room for a while but did not like how the paint peeled off the walls. He was in a recliner with a standing lamp to his left; it was leaning against the blinds. The base was observed behind him, crumbled and unusable. He said he just turns it on and leans it to the side since it can't stand on its own. He apologized for the state of his bathroom and said he would clean it today. He said, he requested a new room because he was worried about falling on the hardwood floor, but his requests were ignored. He said housekeeping comes about once a month, but they used to come more. When asked how he would alert the staff if he needed help, he said he would use the pull cord

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968987	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ASSISTED LIVING FACILITY, LLC	319 ELDRIDGE AVE ORANGE PARK, FL 32073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 9 in the bathroom. (Photographic evidence obtained) At 10:00 am on , Resident #5 was interviewed in her room. She explained she had no bathroom door because the previous resident removed it, but she would like something set up to separate the bathroom from the living area. A small fridge was sitting on the countertop next to her handwashing sink. When attempting to open the fridge, it shifted about an inch, and a live bug was seen crawling from underneath onto the wall. Behind the fridge, several bugs were seen. Live bugs were also observed on the wall in her living area. (Photographic evidence obtained) Resident #6 was interviewed on at 10:18 am. When describing his bathroom, he stated, "It needs work!" The toilet had black residue extending through the entire inside of the bowl. He demonstrated how he has to flush his toilet: He removed the top of the toilet tank, took the long shower hose from his shower to the left of the toilet, and filled the of the tank with shower water. He said he does this every time he needs to flush. The handwashing sink had a layer of residue extending from the countertop to the drain. The bedspread had visible stains, as did the sheets and pillowcase. Several live bugs were seen during his interview both on his bed (it crawled across the notebook he was writing in) and on the nightstand next to his bed. He explained he had been in several rooms, and they all had bug issues. (Photographic evidence obtained) Resident #7 was observed in his room, sitting in his wheelchair, on at 10:43 am. His toilet was also filled with gray/orange residue which appeared to have been building up over time.	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968987	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ASSISTED LIVING FACILITY, LLC	319 ELDRIDGE AVE ORANGE PARK, FL 32073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 10 (Photographic evidence obtained) Employee B, daytime caregiver, was interviewed on at 9:00 am. She explained they used to have certain days to clean rooms. Now, cleaning is just done as needed. They used to have a set schedule but because they had so few residents, "When we're in the room, we do it." When asked when the last time she cleaned Resident #3's room, she said "It's been a while ... if you're the only one here, it gets overlooked. If you must choose between helping a resident and cleaning a room, you're going to assist the resident." She also explained the resident call system doesn't work. The computer used for resident call system alerts behind the reception area was observed during the interview, and the screen was black. She said the nurse's station call system isn't accurate because it displays names of residents who no longer live here. At 9:30 am on , Employee A, caregiver, was interviewed in the nurse's station. She confirmed the names displayed were former residents and she did not rely on the call system to know when residents needed help. She was asked about the facility housekeeping practices. She got up and killed a roach during the interview. She said they clean as they go into rooms but did not cite an actual schedule. She acknowledged maintenance issues were taking a while to get fixed. Resident #1 was interviewed in his room on at 10:30 am. He expressed concerns over the conditions in his room. Observations of the floor showed it was caked with residue around the entry. The bathroom contained a sink area, shower, and toilet. The shower was partially blocked by a shelf and the actual shower area	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968987	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ASSISTED LIVING FACILITY, LLC	319 ELDRIDGE AVE ORANGE PARK, FL 32073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 11 was partially used as storage. Behind the belongings in the shower, roaches were observed. He explained the last time he received housekeeping services was about four months ago. He purchased a mop online so he could clean his own floors. The mop was observed in the bathroom area, sitting on top of the toilet tank topper which was upside down on the ground. Review of Resident #1's 1823 Health Assessment showed he was not independent with activities of daily living (ADL's) and needed assistance with bathing, , toileting, and transferring. (Photographic evidence obtained) The Administrator was interviewed on at 12:36 pm. She explained they last had a full-time maintenance person in . The roof had been leaking for years, every time it rained. The property owners received two estimates but she confirmed to date, no repairs have been done. She acknowledged plumbing issues in several areas, including some resident toilets. The toilets were onsite, but her plumber couldn't install them due to personal issues. She said they had been onsite for "awhile." When asked if she called a different plumber because the first one couldn't come out, she confirmed she hadn't. A section of fencing located between the odd numbered resident rooms and the neighboring property was observed with the Administrator on at 1:50 pm. It was loosely nailed to the wall and was spray painted with the word "STAY OUT" in orange. She said it has been up for years. She did not know the exact reason but guessed it had something to do with resident	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968987	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ASSISTED LIVING FACILITY, LLC	319 ELDRIDGE AVE ORANGE PARK, FL 32073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 12 safety. (Photographic evidence obtained) A second observation of Resident #3's room was made on at 1:52 pm with the Administrator present. The room appeared in the same condition with no improvements from the original observation on . The AC Unit was still covered in debris. Floors remained dirt ridden, and the bathroom wall was still missing. She said it was replaced in but did not know how long it had been open for. The bathroom now had many tiny flying insects. The unattached faucet was pointed out and she did not have a response for why it wasn't attached. She alleged she personally cleaned the room on Monday, 3 days before the first observation, but several areas including floors, countertops, and the trash appeared to have several layers of build-up that appeared to take time to accumulate. When the trash that was full of flies and caked on debris was pointed out, she then said, he didn't want people coming into his room to help. She said he would call her names, so she didn't like coming into the room. At 2:09 pm on , the Administrator explained the housekeeping schedule was as follows: Monday, Wednesday, and Friday, they were supposed to clean even numbered rooms. Tuesday, Thursday and Saturday, they were to do odd numbered rooms. She admitted housekeeping was not happening routinely. When told the residents reported a lack of housekeeping services, she alleged they weren't telling the truth. Review of the job descriptions for Employees A and B revealed a job summary that read: "Performs resident care activities and services	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968987	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ASSISTED LIVING FACILITY, LLC	319 ELDRIDGE AVE ORANGE PARK, FL 32073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 13 necessary in caring for the personal needs, safety, and comfort of residents assigned." For resident safety, they were to "Keep the resident living area neat and orderly: personal care items stored properly; clothing hung up in closets or placed in soiled bins as appropriate. Make resident's bed, including changing linens as necessary." (Photographic evidence obtained) Review of the resident contract revealed the following: basic services on page 6, #3. "Maintenance": facility will perform all necessary maintenance and repairs of the room due to normal wear and tear at its own expense. Page 8, #4. "Housekeeping and Laundry Assistance": housekeeping and laundry will be available once a week. Page 8 also explained in the "Basic Personal Care-Related Services" section that, "Staff will be available 24 hours per day to provide residents with needed services ... Services will be available according to the rules and statues directed by the Agency for Health Care Administration and the Department of Elder Affairs." (Photographic evidence obtained) Class I	A 030		
A 079 SS=L	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 212 16-25 253	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968987	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ASSISTED LIVING FACILITY, LLC	319 ELDRIDGE AVE ORANGE PARK, FL 32073

(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 079	Continued From page 14	A 079		

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 [illegible] ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times.
a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement.
b. A nurse is considered as having met the course requirements for First Aid. An emergency

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968987	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ASSISTED LIVING FACILITY, LLC	319 ELDRIDGE AVE ORANGE PARK, FL 32073

(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 079	Continued From page 15 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 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.	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968987	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ASSISTED LIVING FACILITY, LLC	319 ELDRIDGE AVE ORANGE PARK, FL 32073

(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 079	Continued From page 16 (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 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	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968987	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ASSISTED LIVING FACILITY, LLC	319 ELDRIDGE AVE ORANGE PARK, FL 32073

(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 079	Continued From page 17	A 079		

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 record review, interview, and observation, the facility failed to ensure minimum weekly staffing requirements were met according to regulation. Failure to ensure the minimum staff were available to meet resident needs affected the living conditions of all 16 residents evidenced by facility wide neglect in maintenance and housekeeping, as well as the lack of ability to effectively assist residents in event of an emergency.

The findings include:

At 1:24 am on , an officer from Orange Park Police Department was interviewed. He stated there were times he has been called to service at this facility and has had difficulty getting anyone to answer the door after hours. He also said he has been approached by families trying to get in contact with their loved ones but couldn't reach anyone.

On at 1:28 am, upon approaching the facility, signs were posted at the main entrance to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968987	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ASSISTED LIVING FACILITY, LLC	319 ELDRIDGE AVE ORANGE PARK, FL 32073

(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 079	Continued From page 18	A 079		

call a specific phone number to gain entry. The side entrance was being used. There was one car observed in the parking lot. The Administrator confirmed at 1:30 am on that she was the only employee here until 6 am, when Employee A would arrive, and the Administrator's shift would end around 10 or 11 am.

Timecards showing the exact times staff clocked in and out for the week preceding the survey were requested on at 4:34 am.

At 7:50 am on , Resident #3 was interviewed. He stated he had never had a housekeeper come in. He described the facility as "grossly understaffed" and explained he had lived here several years and saw the steady decline of available staff for services such and housekeeping and maintenance. Observation of his room showed a large section of the wall missing paneling in the bathroom, floors covered in a layer of debris, and debris covering his AC unit. Photographic evidence obtained.

At 9:15 am on , a representative from the Orange Park Fire Department (OPFD) was interviewed telephonically. He explained earlier this week they arrived onsite to answer a distress call for a resident. Upon arrival, the resident was located in his room "supine on the ground" and his team assisted in lifting him into the wheelchair. He explained his team arrived at the entrance and no one answered the door, so they went to the opposite side of the building and took part of the fence paneling down to gain entry. They eventually found an employee to help, but staff was not immediately available to help the resident. He explained there was a pattern of his team having to go in through the fence because no one was available when they arrived at the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968987	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ASSISTED LIVING FACILITY, LLC	319 ELDRIDGE AVE ORANGE PARK, FL 32073

(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 079	Continued From page 19 entrance. Resident #6 was interviewed on . . . at 10:18 am. When he asked to view his bathroom area, he responded, "It needs work!" The toilet had black residue extending through the entire inside of the bowl. He demonstrated how he has to flush his toilet: He removed the top of the toilet tank, took the long . . shower hose from his shower, and filled the . of the tank with shower water. He said he does this every time he needs to flush. The handwashing sink had a layer of residue. The bedspread had visible stains, as did the sheets and pillowcase. Several live bugs were seen during his interview. He explained he had been in several rooms, and they all had bug issues. (Photographic evidence obtained) Resident #6 explained he was the Resident Council President. When he was asked if staff were aware of the housekeeping and maintenance issues, he said they are always talking about it in meetings and staff had been made aware. He said the response from staff was that they would address the issues when they had more staff to do so. When asked the last time housekeeping had come into his room, he said it was around Thanksgiving. Other residents were complaining about toilets not working. Resident #6 expressed concern over two Resident #7 experienced in which he had to assist staff with. He was asked whether he attempted to get staff before lifting Resident #7 off the ground. He stated he had to help, because Resident #7 was so heavy, he required two people to get him up when he . Employee B, daytime caregiver, was interviewed on at 9:00 am. She explained they used to	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968987	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ASSISTED LIVING FACILITY, LLC	319 ELDRIDGE AVE ORANGE PARK, FL 32073

(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 079	Continued From page 20	A 079		

have assigned days to clean rooms. Now, cleaning is just done as needed. Because they had so few residents, "When we're in the room, we do it." When asked when the last time she cleaned Resident #3's room, she said, "It's been a while ... if you're the only one here, it gets overlooked. If you have to choose between helping a resident and cleaning a room, you're going to assist the resident."

She explained she did not think the facility was staffed in a way to ensure resident needs were met in an emergency. For residents to gain her attention, "they can either yell out and she'll hear them, or use the call system." When she presented the facility call system located next to the reception desk, the screen was blank. She said it didn't work.

At 9:30 am on , Employee A, overnight caregiver, was interviewed. She described a Resident #7 experienced. She said she had to have Employee B come assist him into his wheelchair. When working alone, if a resident required a two person assist, she would rely on Emergency Medical Services ( ) to come assist her. Employee A also stated the call light system was not functional in the facility. The scrolling alerts alarming in the nurse's station were old and the residents listed didn't even live here anymore. She has given her personal cell phone number to a few residents, so they could call her if they needed her.

She continued on to explain the procedures to follow if a fire broke out. She would get residents to a central location, but would rely on upstairs residents to bring fire extinguishers down with them. She said she would need to go help Resident #1, Resident #2, and Resident #7. She

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
	AL11968987	A. BUILDING: ______ B. WING ______	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ASSISTED LIVING FACILITY, LLC	**319 ELDRIDGE AVE ORANGE PARK, FL 32073**

(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 079	Continued From page 21	A 079		

stated more staff than what they currently had scheduled were needed to cover everything in the event of an emergency . Employee A confirmed she needed the help of Employee A to lift Resident #7 after a , and when working alone, she relied on to come assist.

She confirmed that she was working the night came to assist Resident #1 earlier this week. She was working alone and had used the restroom and did not know they were trying to gain entry.

Resident #1 was interviewed at 10:30 am on and confirmed he recently had to call 911 to get help off the floor after a in his room. He said he tried reaching staff for help first, but no one came. The team arrived around 3:00 am. He said they entered the facility by taking the fence posts down. According to Resident #1, this also happened approximately 3 months ago, when he called 911 for help after another . He said the team reported difficulty getting in because they couldn't find staff. Resident #1 sat in a wheelchair during the interview and explained he had left side , and was reliant on staff help in an emergency.

Review of the schedules for Employees A and B, who both stated they felt their shifts did not have coverage to help residents in the event of an emergency, showed they were scheduled as the only caregiver on the following dates:
Employee A: , , and .
Employee B: , , , , , , and . (Photographic evidence obtained.)

A list of the current staff was provided by the Administrator showed she had three dedicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968987	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ASSISTED LIVING FACILITY, LLC	319 ELDRIDGE AVE ORANGE PARK, FL 32073

(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 079	Continued From page 22 direct care employees: Employee A, Employee B, and Employee C. Employee D was listed as dietary but direct care as needed. The schedules starting the week of showed med techs on duty during the week. Two caregivers were taken off the schedule in , but one was added. Three more caregivers were off the schedule by the end of with no new additions in subsequent weeks. (Photographic evidence obtained) At 2:09 pm on , the Administrator agreed to email the timecards for the previous week, which were first requested on , as they had not yet been produced. Regarding scheduling, she stated her goal was to schedule 300 hours per week. When current schedules were presented, she said she had roughly 275 hours of direct care scheduled. Employees A, B, and C were scheduled the week prior to the survey through the current week, and into the next (ending .) She explained Employee D worked in the kitchen until 2:00 pm on her shift, when she would then do direct care until 7:00 pm. She included Employee D in the count of direct care workers when quoting how many hours of direct care she had. Employee D was interviewed at 2:45 pm on . She was in the kitchen at the time cleaning dishes. The kitchen was a large industrial setting, located in the of the dining room. It was not adjacent to any resident living areas and no residents were seen in the area at the time. She explained she would help if someone came and asked her for help; otherwise, she was busy with dietary duties, like cooking dinner. The location of the kitchen was	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968987	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ASSISTED LIVING FACILITY, LLC	319 ELDRIDGE AVE ORANGE PARK, FL 32073

(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 079	Continued From page 23 approximately a minute and a half walk to the area resident rooms were located. Observation throughout the building during the entirety of the survey directed callers to use their after-hours number to reach staff if needed. It was posted on outer doors for outside visitors or third-party agencies to use; it was also posted inside the building. Also observed was a section of fencing along the perimeter with a section labeled "OPFD." The Administrator confirmed in an interview at 1:58pm on that in the event of an emergency, if or police arrived and needed to gain entry, they could call her cell (the number posted on the signs), and she would call the staff person on duty to answer the door for them. If staff didn't answer the phone, she would call their personal cell phone. She said they also keep an out for flashing lights to know emergency personnel needed entry. She explained the outer fence area panels were for emergency use only in case there was a fire and they needed to enter in an emergency and could not reach anybody. (Photographic evidence obtained) At 3:14 pm on the Administrator confirmed there were 16 residents in the facility. She acknowledged the staffing She estimated the last time there was a full-time housekeeper was , and she had been having difficulty hiring staff. She confirmed the care and services declined with the decline in staffing, and that residents were complaining about it. Review of the resident contract revealed the following: Basic Services on page 6, #3. "Maintenance": facility will perform all necessary maintenance and repairs of the room due to normal wear and tear at its own expense. Page 8,	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968987	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ASSISTED LIVING FACILITY, LLC	319 ELDRIDGE AVE ORANGE PARK, FL 32073

(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	Continued From page 24 #4. "Housekeeping and Laundry Assistance": housekeeping and laundry will be available once a week. Page 8 also explained in the "Basic Personal Care-Related Services" section that, "Staff will be available 24 hours per day to provide residents with needed services ... Services will be available according to the rules and statues directed by the Agency for Health Care Administration and the Department of Elder Affairs." (Photographic evidence obtained) Timecards showing the exact number of hours worked by Employees A-C were not produced until at 4:23pm. There were not timecards for the window of time originally requested (the week preceding the survey, from Thursday to .) Timecards for direct care workers were requested; she included Employee D in the timecards she emailed, despite Employee D confirming she was a kitchen worker and only helped if someone approached her for help. There were discrepancies between the schedules presented and the actual hours worked. The schedule for -29, 2022's dates did not line up with the days of the week. The schedule showed Employee A was to work Thursday that week, but her timecard showed no hours worked. She was scheduled that Saturday, but it was scratched out showing she was off. 11PM-7 am was written above it. Her timecard showed she did not work that shift. No other employees were shown as scheduled from 11 pm Saturday to 7 am Sunday. The Administrator was scheduled from 7 am to 11 pm, and Employee B working 7 am to 5 pm. Employee B only worked until 3 pm on Saturday according to her timecard. (Photographic evidence obtained.)	A 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968987	A. BUILDING: _____ B. WING _____	02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ASSISTED LIVING FACILITY, LLC	319 ELDRIDGE AVE ORANGE PARK, FL 32073

(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 079	Continued From page 25 When staffing totals were added up (based on actual timecards from Employees A-C, and the scheduled hours of the Administrator since she does not clock in and out), they did not meet the 275 hours the Administrator claimed to have scheduled for direct care. The week preceding the survey, from [redacted] to [redacted], reflected 236 hours worked, falling short of the required minimum of 253 hours. The week starting [redacted] only had 156 hours scheduled between Employees A, B, and C, and the Administrator. Several shifts for the Administrator were only listed as needed (PRN). No coverage was scheduled for Saturday [redacted] after Employee B's morning shift, only "PRN" next to the Administrator's name for the afternoon and overnight shifts. (Photographic evidence obtained.) Class I	A 079		