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
	AL11965638	A. BUILDING: _____ B. WING _____	R 05/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GULF HAVEN, INC.	6343 ROWAN ROAD NEW PORT RICHEY, FL 34653

(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 revisit to the complaint investigation (#2022002538) was conducted at Gulf Haven, Inc. on . Deficiencies were identified at the time of the visit.	{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 or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . 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 for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	A 025		

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A 025	Continued From page 1 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 the personal supervision and oversight required for each resident, to include awareness of general health, safety, and well-being for 1 (Resident #1) of 21 residents. The lack of oversight and awareness of Resident #1's elopement led to an absence from the facility for approximately 7 hours before the facility was notified by the resident's family that she was missing. The lack of resident supervision procedures placed all residents at imminent risk of serious injury or harm. Findings Included:	A 025		

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A 025	Continued From page 2 In an interview with Resident #1 conducted on [redacted] at 10:00am, she stated "I am not too [redacted] with the night staff. It took them hours to know I was gone last night. [...] I walked all the way to Holiday and it took me over two hours. I got a ride when I was three minutes away. I am with [redacted]. My mom had me sleep there since I got there at 1:00am. My mom drove me here later in the morning when she knew I was ready." In an observation conducted in the facility's kitchen on [redacted] at 10:35am Resident #1 (walked in and said to the Administrator) that she walked to her mom's house from the facility the day before. Resident #1 stated "I just said I have to get to my mom's. I did not even stop for food or water. I had to tell a guy driving by that I did not need a ride a few times. I just kept on walking and ignored him. I ended up getting a ride from a nice girl for the last 3 minutes. I had written directions to my mom's house, so I knew where I was going. The new lady [Staff B] just sits there and does not help much. She does nothing. She is the lady who stays here at night." Record review for Resident #1 conducted on [redacted] revealed a facility admission date of [redacted]. She had diagnoses of [redacted] type, [redacted], and [redacted] spectrum [redacted]. Resident #1's health assessment dated [redacted] revealed she was not an elopement risk, was independent with activities of daily living and required assistance with self-administration of medications. Record review conducted on [redacted] revealed the form titled "Resident House Policies and	A 025		

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A 025	Continued From page 3 Procedures" signed by Resident #1 on had a category of "Sign-in and out" at the bottom of page 2 that extended to page 3, stating "Please sign-in and sign-out as a courtesy measure so staff is aware if you are at the facility. Please inform staff if you are going to be away for any extended periods of time. This information is especially important in cases of emergency and for your safety." A review on . . . . . of the facility's undated elopement policy and procedure revealed the following: Purpose: This procedure is used when a resident is missing from the facility Policy: The following procedure is to be followed by MedTech (Medication Technician) on Duty. Procedure: 1. Review Quick MOR (medication observation record) Resident in or out of the facility. 2. Review tasks (QuickMar) for scheduled , , . 3. Provide a thorough search of the building both inside and out. 4. Ask all residents the last time they may have seen the resident in question. 5. Provide a check of 7-Eleven next door. 6. Contact the administrator if the resident is still not located. 7. ALF (Assisted Living Facility) Incident Report Form is to be completed by MedTech 8. Administrator will: a.) advise to call sheriff, b.) contact resident's emergency contact, c.) complete an Adverse Incident Report and submit to AHCA (Agency for Healthcare Administration)."	A 025		

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A 025	Continued From page 4 In an interview with the Administrator conducted on [redacted] at 10:35am she stated "I did not know it was an issue. Her elopement is not on record." The Administrator stated it was Staff B that was on duty the night Resident #1 left and that they are not a locked facility. Staff A told Resident #1 not to do it again. She said "both [Staff A] and I talked to her mom and [Staff A] talked to her case worker about the elopement." The Administrator further stated she had planned to meet with Resident #1's case manager and mother that day at 2:00pm to reevaluate Resident #1. Additionally, she said she had not notified the primary care physician of the elopement and "her case manager will address it with her psych [redacted] doctor, as I see it as more of a psych issue." In an interview with Resident #6 conducted on [redacted] at 10:45am, she said she leaves without telling staff all the time. In an interview with Staff A, Medication Technician, conducted on [redacted] at 11:11am, she stated she knew Resident #1 was at her mother's house at 7:00am and the resident got to the facility at 10:00am on [redacted]. Staff A stated on [redacted] Resident #1 was sitting outside and "apparently just got up and walked off." Staff A stated Staff B had not notified anyone of Resident #1 elopement and only told her when she arrived for work at 7:00am. She said Staff B was on duty when it happened and was a new employee. In an interview with the Administrator conducted on [redacted] at 11:15am she said Staff B did not know Resident #1 was missing and did not call her. She said that Resident #1 is not	A 025		

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A 025	Continued From page 5	A 025		

someone that "you go into her room on a regular basis and has no physical help issues. The residents are up and down and in and out all night. We did not know she was gone until her mom called and [Staff B] called me." Additionally, she said "we cannot go in every room every two hours to check, I mean then we would have another complaint we are waking them up all the time. We do not go into the rooms all the time to see if they are or alive. We would only go in their room if they had health issues and right now, we have no residents. I have not set the expectation that they have to see a resident every two hours because the staff would be in a tailspin all the time. We ask them to let us know when they go and notify us when they leave the building, so we are not worried about them. I did not know she was an elopement risk, and she does not have 's and Yes, she has , but we have a number of residents with this, and they do not off. Now I am hearing that she has done this in the past. I have called the police in the past for [Resident #2] who knew where he was going and had a plan. They are adults even though they heave mental health issues. He would stay in the park down the street and one time he was gone for three days without his medication. We found him accidentally someplace else. He walks everywhere all the time."

In a review of Resident #2's record conducted on his Health Assessment dated , revealed he was diagnosed with and was not marked as an elopement risk.

In an interview with Staff A conducted on at 12:40pm. she stated she was "assuming the information on [Resident #1] came

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A 025	Continued From page 6 from another resident. All [Staff B] said was that she was not here and was at her mother's. As soon as I clocked in I started getting calls from [Resident #1's] case manager and her mother. Her mother called the case manager at 1:00am." In an interview with Resident #1's mother conducted by phone on at 12:44pm she stated that the Resident #1 decided to walk to her house and arrived at approximately 1:15am on . She stated "I notified her [Resident #1's] case manager and someone from the facility. I waited until morning because she was safe, and I did not want to wake anyone up." Additionally, she said she had no idea Resident #1 was coming to her house and "I thought she was done with this and was not going to do it anymore but of course, she goes online and gets ideas. She has some issues. I called the new girl on the graveyard shift [Staff B] between 6:00am and 7:00am at the facility number and let her know that she [Resident #1] was safe." In a phone interview with Staff B, Caregiver, conducted on at 12:51pm, she stated that she did not know what happened with Resident #1. She said she got a call from Resident #1's mother on around 6:08am saying that Resident #1 was at home with her. She said when she came on shift at 11:00pm on that Resident #1 had already left the facility. She stated "I can't be sure. I saw someone leaving the facility front yard at 11:00pm who was shaped like [Resident #1] but there are two residents shaped alike." Additionally, she said the residents come in and out and have access to come and go as they please. She said, "some come and go and stay gone and come ." She said Resident #1's bedroom door was closed and that they do not enter the rooms if the doors	A 025		

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A 025	Continued From page 7 are closed. She said, "we cannot do a visual on them every so often, we just can't." She said she has not had elopement training since she started at the facility. In an interview with the Administrator conducted on [redacted] at 1:00pm, she stated they do not assess residents for elopement risk. She stated "No, I usually just ask the individual or the case manager and they give me the background. There was nothing about her [Resident #1] taking off. We just go by the case manager information and the health assessment." In a phone interview with Staff C, Caregiver, conducted on [redacted] at 1:06pm he said that residents usually tell him if they leave the property, but that Resident #1 did not tell him if she was leaving. He said "we do not hold them against their will, I tell them to tell us when they leave so we can mark them out in the system." He said he has not had "an elopement update or anything and I have a limited mental health training to do." He said he has not been a part of any elopement drills and that "we just make sure we do what we are supposed to do and check to see if everyone is okay." In an interview with Staff A conducted on [redacted] at 1:40pm she said the only other resident with an elopement risk that she could think of was Resident #2 "because of past stuff". In an interview with Resident #5 conducted on [redacted] at 1:55pm, he stated " I asked them when I came and they said there were no house rules. They said to tell them when I leave. They know I don't tell them when I go to the store to get cigarettes and are okay with it."	A 025		

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A 025	Continued From page 8 In a phone interview conducted with Resident #1's case manager on at 2:30pm, she stated she was told by the resident's mother about Resident #1's elopement and that there was no formal meeting planned by the facility. She stated she was planning to see Resident #1 the next day. In a review of the facility's elopement drills conducted on there was a record of one drill dated by the Administrator with no staff signatures or attendees listed. In an interview with Resident #5 conducted on at 10:25am he said "If overnight, I have to give them an emergency contact number, but I don't tell them if I go next door for cigarettes or on the bus for food. They don't care, they don't have any rules here". In a record review conducted on of in-house incident report folder. There were no reports of Resident #1's elopement and there were no reports dated past 2017. Photo Evidence Obtained. Class I	A 025		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed	A 032		

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A 032	Continued From page 9	A 032		

for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days.

1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times.

2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative.

(b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for:

1. An immediate search of the facility and premises,

2. The identification of staff responsible for

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A 032	Continued From page 10 implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to document direct care staff participation in the facility elopement drill and include a review of procedures to address resident elopement. Findings included: A review of the facility elopement drills conducted on . .. . revealed a form entitled "Elopement Drill", dated with the [Administrator name] listed under "Staff Involved in search PLEASE SIGN IN BELOW:" It further read: "1:15pm Resident left the facility without informing staff or signing out. The residents were questioned if they had seen individual. A search of the facility was performed. The resident was found next door at 7-Eleven having a beer 2:00pm." There were no staff signatures or names listed on the drill. In a phone interview with Staff C conducted on at 1:06pm he said he had not had an update on elopement training. He stated "No, not really. We just make sure we do what we are	A 032		

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A 032	Continued From page 11 supposed to do and check to see if everyone is okay and is there, or if they are outside smoking or something." In a phone interview with Staff B conducted on at 1:13pm she said she had not had elopement training and stated "not since I have been here, but I have had it. The place is different than the other place I work at that is a memory care facility. These residents have access to come and go as they please. They come and go and stay gone and come ." In an interview with the Administrator conducted on at 11:55am she stated "I don't know who attended, it is usually the staff that is on that day." Photo Evidence Obtained Class III	A 032		
{A 152} SS=G	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	{A 152}		

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{A 152}	Continued From page 12 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 [illegible] to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, [illegible] 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 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 [illegible]. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a safe, clean, and decent living environment for all residents that resided at the facility. Furthermore, the unsafe conditions in and around the facility placed all residents at risk of injury. Findings Included: In a tour of the facility conducted on [illegible] from 9:30am through 5:00pm: First floor interior:	{A 152}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 152}	Continued From page 13 "Cement covering some of the tiles leading into the foyer from the front door where what appeared to be wheelchair marks in the now dry cement remained. "Carpeting in first floor common area covered in dark stains with dirty and broken tiles leading from the common area into the kitchen. "Bedroom 1 to left of front door had water stains on the ceiling in two areas over resident beds "Bedroom 2 to the right off the common area, had dark carpeting stains and a cockroach on the floor. Second floor interior: "Wooden stairway was missing balusters up the full flight of stairs. The only support was a wooden handrail that was wobbly and unstable. "Black dirt and ground in debris on baseboards and floors at the . . . of and outside the bedroom at the front of the house "Bedroom 2 had broken tiles at the edge of the bedroom door and in the hallway. There was a large blue stain on the carpet in the closet. "Bedroom 3 had ,,, tubing and canula laying on the dirty floor. Resident #xxxx was laying in bed with the bottom of a filthy extending out from the covers. There was dirt and debris on the floor throughout the room. "Bedroom 4 had paint rubbed off the wall to the side of the bed headboard. Facility Exterior: "The far side to the rear of the wood plank patio had caution tape on one side at the bottom of the fire escape. There were loose and rotten wood planks at the base of the fire escape stairs and only yellow caution tape hung to one side of the	{A 152}		

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	AL11965638	A. BUILDING: _____ B. WING _____	R 05/17/2022

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{A 152}	Continued From page 14 fire escape stairs and wood plank landing. " Large area of black spots and discoloration that appeared to be a mildew type of bio-growth along the siding of the entire of the house on both floors, including the soffit with bugs, spiders and spider webs throughout. The black bio-growth was darkest near the water faucet by the air conditioner unit in the wall on the of the house leading to the common area. "Loose piece of rubber door seal at the bottom of the French door to the common area. "Flaking paint on the window trims and a pair of dirty sneakers outside the door. "A wire extending from one second-floor window toward another second- floor window. "Rotten wood at areas of the roof line "A exterior light with lightbulb and no cover turned sideways near the door "Wires extending from the second floor along the length of the fire escape second floor to first floor. "yellowed sections of siding along the second-floor rear of the facility. "Black and rotten wood on the 2nd story patio outside Resident #10's room with a stain along the first story cement below it with black bio-growth In an interview with Resident #6 conducted on at 9:56am they said the outside of the facility needed upkeep. In an interview with Resident #1 conducted on at 10:00am they stated the ceiling area around the ceiling fan leaked when it rained, and that Resident #9 patched the leak. They stated until it rained, they would not know if it worked. She pointed out where the water was on the floor that Resident #8 slipped in before she went to the hospital.	{A 152}		

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{A 152}	Continued From page 15 In an observation conducted on in Resident #1's room there was the remains of a water stain on the floor under the area of the ceiling fan. In an interview with Resident #10 conducted on at 10:10am they said the blue stain in the closet was spilled shampoo and was not cleaned by the carpet cleaners. In an interview with the Administrator conducted on . . . . . at 10:25am she said "we have painted the kitchen, the rooms and the stairwell. That is mainly it. I am not sure what fixes you are talking about. I am just going by memory now." She stated "[Resident #9] is Mr. Fix It. It is hard to get anyone to do anything. I hired a painter, and he came now and again after I already paid him. I got my residents painting and pay them in cash to do it. I went down the street to get flooring in here and they said the floor is too uneven and if they put it in, they do not want to be responsible. We put cement over the tile to because he had to fill in the grooves and will put flooring on top." Additionally, she stated that Resident #11 slept with his . . . . on the wall and rubbed the paint off again because that is how he sleeps. She said there was a roof leak in Resident #1's room close to the ceiling fan, and they got it fixed, but she did not have receipts. Additionally, she stated that Resident #8 "stepping over something. I believe they say there was water on the floor." She further stated that sometimes the 2nd floor toilets leak into the downstairs ceiling in bedroom 1 next to the front door and that they had "an issue with one of the pipes leaking." During an interview with Resident #1 conducted on at 2:45pm, she stated she nearly	{A 152}		

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{A 152}	Continued From page 16 ... through the ... patio due to loose ,and rotting boards. An observation of the ... patio conducted on ... at 2:47pm Resident #25 was observed with another unnamed resident smoking on the patio near the front side of the facility where there were several sections of loose, broken, and damaged patio wood planks. The patio floor was a combination of new wood, and faded/bleached variations of red and brown wood with rotten pieces. During an interview with Resident #25 conducted on ... at 3:05pm, he stated that his roommate [Resident #25] in the ... shed had ... through the patio. In an Interview with resident #24 conducted on ... he stated he was scared to say anything about falling through the wood patio because he was worried about what would happen. In a facility record review of any repairs or services conducted on ... there was only an invoice from Stanley Steemer dated ... for a total of 6 areas that totaled $217.50. In an attempted interview with Resident #9 on ... at 4:10pm regarding the work he performed in the facility, he declined to be interviewed. In an interview with Staff D conducted on ... at 5:13pm she stated that [Resident #9] was sanding down the spokes on the stairway railing and that it had been missing for a week or so.	{A 152}		

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{A 152}	Continued From page 17 In an interview with the Administrator conducted on at 4:20pm she acknowledged the unstable patio wood and said "we replace the boards as we go." When surveyor suggested the unstable area be blocked off from residents she stated "we are not a chandelier facility that gets $3000.00 a month." Photographic evidence obtained. Class II	{A 152}		

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CZ827	408.812 FS; 408.8065(3) FS Unlicensed Activity 408.812 Unlicensed activity.- (1) A person or entity may not offer or advertise services that require licensure as defined by this part, authorizing statutes, or applicable rules to the public without obtaining a valid license from the agency. A licenseholder may not advertise or hold out to the public that he or she holds a license for other than that for which he or she actually holds the license. (2) The operation or maintenance of an unlicensed provider or the performance of any services that require licensure without proper licensure is a violation of this part and authorizing statutes. Unlicensed activity constitutes harm that materially affects the health, safety, and welfare of clients, and constitutes . . . . . and neglect, as defined in s. 415.102. The agency or any state attorney may, in addition to other remedies provided in this part, bring an action for an injunction to restrain such violation, or to enjoin the future operation or maintenance of the unlicensed provider or the performance of any services in violation of this part and authorizing statutes, until compliance with this part, authorizing statutes, and agency rules has been demonstrated to the satisfaction of the agency. (3) It is unlawful for any person or entity to own, operate, or maintain an unlicensed provider. If after receiving notification from the agency, such person or entity fails to cease operation, the person or entity is subject to penalties as prescribed by authorizing statutes and applicable rules. Each day of operation is a separate offense. (4) Any person or entity that fails to cease operation after agency notification may be fined $1,000 for each day of noncompliance. (5) When a controlling interest or licensee has an interest in more than one provider and fails to	CZ827		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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CZ827	Continued From page 1 license a provider rendering services that require licensure, the agency may revoke all licenses, impose actions under s. 408.814, and regardless of correction, impose a fine of $1,000 per day, unless otherwise specified by authorizing statutes, against each licensee until such time as the appropriate license is obtained or the unlicensed activity ceases. (6) In addition to granting injunctive relief pursuant to subsection (2), if the agency determines that a person or entity is operating or maintaining a provider without obtaining a license and determines that a condition exists that poses a threat to the health, safety, or welfare of a client of the provider, the person or entity is subject to the same actions and fines imposed against a licensee as specified in this part, authorizing statutes, and agency rules. (7) Any person aware of the operation of an unlicensed provider must report that provider to the agency. 408.8065 Additional licensure requirements for home health agencies, home medical equipment providers, and health care clinics.- (3) In addition to the requirements of s. 408.812, any person who offers services that require licensure under part VII or part X of chapter 400, or who offers skilled services that require licensure under part III of chapter 400, without obtaining a valid license; any person who knowingly files a false or misleading license or license renewal application or who submits false or misleading information related to such application, and any person who violates or conspires to violate this section, commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.	CZ827		

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CZ827	Continued From page 2 This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the Assisted Living Facility failed to obtain a license from the Agency prior to providing care and services that requires an assisted living facility license for 1 of 2 sampled residents (Resident #25). The licensed Assisted Living Facility moved residents into an unlicensed structure operated and maintained by the licensed Assisted Living Facility Administrator. Failure to maintain residents in a licensed location can place the residents at risk of harm, including and neglect. Findings Included: In an interview with Resident #25 conducted on at 3:05pm, he stated that his roommate [Resident #24] who lived with him in the shed had through the patio because of the rotting wood. In an observation conducted on at 3:40pm a large white structure was observed behind the facility. In an observation conducted on of the interior of the large white structure revealed two beds, a small white refrigerator, a 9-drawer dresser with television on top, two wooden chairs, a floor lamp, a square floor fan and various personal belongings. There was a door at the that led to a bathroom with toilet, sink and shower. There was a strong smell of cigarette smoke emanating from inside the structure.	CZ827		

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CZ827	Continued From page 3 In an interview with Resident #24 conducted on . . . . . at 3:49pm inside the large white structure behind the facility, he stated that he lived there and has been there for over 3 years. He said he gets three meals a day and the staff wash his clothes and linens. He said he liked living there and being separate from all the noise. He said they are supposed to clean on Mondays and Wednesdays. He stated "I heard about the place from the hospital when the owner showed up and said she had a place I could stay." He further stated he has had other roommates that "got their medicine up at the house like my current roommate." He said he gets his Medicare check and it goes into his bank account and the facility owner auto-drafts the payment so it is automatically deducted to pay rent." In an interview with Resident #25 conducted on . . . . . at 4:20pm he stated "my insurance pays for it I guess." I eat my meals here, they wash my clothes and I get medication here from them. In a review of the facility's resident roster conducted on . . . . . Resident #25 were not listed. In an interview with the Administrator conducted on . . . . . at 4:35pm she stated that there were two men that lived in the building. She said "we hold his [Resident #25] medication and it to him because they come in bubble packs. We do not administer or assist. He comes to the cart and we him his medications" Additionally, she stated that the resident's brother had his money and dropped off his payment to	CZ827		

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CZ827	Continued From page 4 them each month. She stated Resident #24 is private pay and gave her his debit card number, and she enters it and takes payment once a month. In an interview with the Administrator conducted on at 5:45pm she stated that Resident #24 and Resident #25 live in the . . . and not in the facility. She stated she did not have room in the facility and could not move them into the facility. (Photographic evidence obtained) Unclassified	CZ827		