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
	AL11953679	A. BUILDING: _____ B. WING _____	08/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH GRAND OF SARASOTA	7130 BENEVA ROAD SARASOTA, FL 34238

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A 030 SS=D	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida . . . . Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities;	A 030		

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A 030	Continued From page 1	A 030		

2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and
;
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and standard precautions;
8. The requirements for coordinating the delivery of services to residents by third party providers;
9. Assistive devices; and
10. Physical .

(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.

(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside.

429.28 Resident bill of rights.-

(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a

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A 030	Continued From page 2 facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . . . and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including	A 030		

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A 030	Continued From page 3 the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making for health care services, the provision of or arrangement of transportation to health care , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff	A 030		

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A 030	Continued From page 4 of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of	A 030		

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A 030	Continued From page 5 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 interview, observation and record review the facility failed to ensure assistance with obtaining access to adequate and appropriate health care for 1 (Resident 1) of 1 resident reviewed with hose. The findings included: On at 11:25 a.m., Resident #1 was observed in his room with Advanced Practice Registered Nurse #2 (APRN #2). Resident #1's lower were observed to have ankle socks on, and were very and red. APRN #2 examined Resident#1's and asked if he had hose. Resident #1 said he did and instructed her to look in a blue bag hanging in his closet. APRN #2 looked in blue bag and pulled out a pair of black hose.	A 030		

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A 030	Continued From page 6 APRN #2 applied the [redacted] hose to his [redacted]. Administrator came in the room at this time and said she was aware facility staff could place [redacted] hose on residents and that Home Health was not required to do that. Review of Resident #1's chart on [redacted] revealed an order from APRN #1 dated for [redacted] high [redacted] stockings, on in the morning and off at hour of sleep. On [redacted] at 9 a.m., Resident #1 said he had always had the [redacted] hose available since he had been at the facility. He said prior to APRN #2 putting them on him the previous day, no one had ever put them on him. He said he was unable to put them on by himself. On [redacted] at 9:37 a.m., Resident Care Coordinator Staff C (RCC) said she was aware that Home Health was not needed to do [redacted] stockings. She said she had not known Resident #1 had [redacted] stockings and she had not talked to him about them. She said she could not account for that; it had been an oversight on her part. Class III	A 030		
A 054 SS=G	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name	A 054		

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A 054	Continued From page 7 and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known [illegible] the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical [illegible], the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure staff were charting properly each time a medication is taken, any missed dosages, refusals to take medications or medication errors. The facility also failed to update resident medication observation record when new medications were ordered for 2 (Residents #1, and 2) of 6 charts sampled. The findings included: 1. On a review of Resident #1's chart revealed an order from the Advanced Practice Registered Nurse #2 (APRN) dated for	A 054		

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A 054	Continued From page 8 ( ) 40 milligrams (mg) by every day for 5 days, 20 milliequizalent by everyday for 5 days, and ( ) 100 mg by twice a day for 10 days with diagnosis including and upper and lower extremities. These medications were not listed on the Medication Observation Record (MOR). These medications were found in the med cart and revealed the had been given once, the had been given 3 times, and the had been given 3 times on the morning shift and had not been given at all on the evening shift. On at 9:37 a.m., Resident Care Coordinator (RCC) Staff C said she was responsible for adding new medications on the MOR. She could not explain why Resident #1's MOR had not been updated with the new orders. On at 11:25 a.m., APRN #2 said if Resident #1 was not getting his meds consistently it could cause his conditions to worsen. 2. On at 9:50 a.m., Surveyor and RCC Staff C reviewed a medication on Resident #2's MOR. This medication was Tab 70 mg (medication for bones) take one tablet by one time weekly on Friday on an empty with oz of fluid and drink. No Food, meds or Fluids and sit up for 10 minutes. The box had a large red stop sign shaped sticker that read: High Alert Double Check. The pharmacy label said 4 tablets were dispensed . The medication box was empty. Fridays in of 2022 on and . The MOR was documented that the	A 054		

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A 054	Continued From page 9 medication had been given on , 2, 3, 4, 5, 11,12,13, 14 and 16/22. Staff C said she could not explain why the box was empty or that the medication had been being given correctly. On at 11:20 a.m., in a telephone call with the Pharmacist, she said the was dispensed on and delivered to the facility on . She said there should be 3 tablets left if it was being given only every Friday. The Pharmacist said the high alert sticker on the box was to alert the nurse or med tech to pay attention that the dosage is only once a week. The Pharmacist explained if given too often it could cause , and other irritations. Pharmacist said taking it every day it would be possible to overdose and cause many serious side effects. On at 5:15 p.m., the Administrator said she had recently taken over for the former Administrator and had not been aware of the problems occurring. Class II Photographic evidence obtained	A 054		
A 056 SS=H	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal	A 056		

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A 056	Continued From page 10 drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly	A 056		

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A 056	Continued From page 11	A 056		

documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable.
(f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner.
(g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following:
1. Practitioner's name,
2. Resident's name,
3. Date dispensed,
4. Name and strength of the drug,
5. Directions for use; and,
6. Expiration date.
(h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order.

This Statute or Rule is not met as evidenced by:
Based on record review, observation and interview, the facility failed to ensure all residents medications were filled or refilled timely. The

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A 056	Continued From page 12 facility also failed to ensure physician orders for medications were followed for 5 (Resident #'s 1, 2, 3, 4, and 5) of 6 residents reviewed for medications. The findings included: 1. On at 9:54 a.m., Resident #1 said he hadn't had some of his medications for 3 days. He said he was supposed to get , (. . , . medication) twice a day, but he had not been getting it. He said he did have , and it did help alleviate it when he gets the medication. On at 11:09 a.m., Staff A (med tech) agreed Resident #1 had been missing some meds. She said they were taught to document a medication not given by circling their initials on the date for that med and document why it was not given on the . . . of the Medication Observation Record (MOR). Staff A said when a med is empty, she places the empty . . . . card on the Resident Care Coordinators desk. Staff A said she had placed his empty . . . . , . . . card there. Staff A said someone is supposed to order the medications when they reach the last row in the pack that is outlined in blue. On at 11:09 a.m., Surveyor and Staff A compared the medications on . . for Resident #1 to his MOR. The following medications were not on . . : , , . . . tab 10 milligrams (mg) take one tab by . . . once daily for . , ... This med was documented with circled initials at 8 a.m. on . . . , . . . , and . . . . . Nothing was documented on the of the MOR. 40 mg one tablet by every	A 056		

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A 056	Continued From page 13 night at bedtime for . This medication was documented with circled initials on and . Nothing was documented on the of the MOR. , tab 75 mg one tablet by once daily for . This med was documented with circled initials at 8 a.m. on , , and . Nothing was documented on the of the MOR. Ferosul 325 mg one tablet by twice daily for . This med was documented with circled initials at 8 a.m. on and and at 5 p.m. on , 15, and 16/22. The of the MOR had an entry for which read, "out of evening meds". 5 mg one tablet by once daily for retention. This medication was documented as given however it was not on the medication cart. , cap 400 mg one capsule by twice daily for . This medication was documented with circled initials at 5 p.m. on , 15 and 16/22. Nothing was documented on the of the MOR. 2.5 mg tab one tablet by every 12 hours. This medication was documented with circled initials for 8 a.m. on , 16 and 17. The of the MOR had an entry on reading, "out of evening and bedtime meds". , tab 40 mg one tablet by once daily for . This medication was documented with circled initials for 6 a.m. on and 16/22. The of the MOR had an entry on reading, "out of evening and bedtime	A 056		

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	AL11953679	A. BUILDING: _____ B. WING _____	08/18/2022

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A 056	Continued From page 14 meds". Cap 0.4 mg one capsule by every night at bedtime for . This medication was documented with circled initials for 8 p.m. on and . The of the MOR had an entry on reading, "out of evening and bedtime meds". C Tab 500 mg one tablet by twice daily for . This medication was documented with circled initials at 8 a.m. on , 15, 16 and 17/22 and 8 p.m. on and 16/22. The of the MOR had an entry on reading out of evening and bedtime meds. On a review of Resident #1's chart revealed an order from the Advanced Practice Registered Nurse #2 (APRN) dated for ( ) 40 mg by every day for 5 days, 20 milliequevalent by everyday x 5 days, and ( ) 100 mg by twice a day for 10 days with diagnosis including , , , and upper and lower extremities. These medications were not listed on the MOR. These medications were found in the med cart and revealed the had been given once, the had been given 3 times, and the had been given 3 times on the morning shift and had not been given at all on the evening shift. On 11:25 a.m., the APRN #2 said if Resident #1 was not getting his meds consistently it could cause his conditions to worsen. On at 2:11 p.m., the Administrator said and meds as needed (PRN) are	A 056		

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A 056	Continued From page 15 supposed to be re-ordered when there is a 5-day supply left. She said regularly scheduled meds are on an auto cycle with the pharmacy and delivered every 30 days which is normally before the 10th of the month. The Administrator said she had not known there was an issue with medications not being on . . . On . . . . . at 11:20 a.m. in a telephone call with the Pharmacist, she said the process was if a request is faxed in, then it is filled within 5 days. She said if the facility needed the med sooner than that they were supposed to make a telephone call to request the med. The pharmacist explained they had received a faxed request for Resident #1's medications on . She said no one called the request in and said they needed it earlier. She said that was why the medications weren't available at the facility. 2. On . . . . . at 12:45 p.m., Resident #2 said the staff gave her the wrong medicine a lot of the times. She said she did not know which days but that she knew her meds and caught it. Resident #2 said her medications are not always there and they gave her the excuse that they changed pharmacies. She said she had a medication for her that really helped her, but the doctor changed it to over the counter and she I didn't know why. On 1:08 p.m., Surveyor and Staff A (med tech) compared the medications on . . . for Resident #2 to her MOR. The medications listed on the MOR were on . . , however there were additional meds present for Resident #2 that were not listed on Resident #2's MOR. These medications were , 2 mg take 2 capsules (cap) after first loose . . . then 1 cap for every loose . as needed do not exceed 8	A 056		

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A 056	Continued From page 16 capsules per day and the other medication was ODT give 1 tablet by … … every 8 hours as needed for … … and …. Both medication labels from the pharmacy were dated … …….. On … … at 9:50 a.m., Staff C (Resident Care Coordinator) said she did not know why these additional medications were on … or why they were not on the MOR. She said even if the resident was self- administering these, they should be on the MOR. Staff C said she did not know when or if they had been discontinued. At this time the discontinue order was requested from Staff C. On … …… at 11:35 a.m., the discontinue order was requested a second time, this time from the Administrator. The discontinue order was never received. On … at 9:50 a.m., Surveyor and Staff C (RCC) reviewed a medication on Resident #2's MOR. This medication was … Tab 70 mg (medication for bones) take one tablet by … one time weekly on Friday on an empty … … with … oz of fluid and drink. No Food, meds or Fluids and sit up for 10 minutes. The box had a large red stop sign shaped sticker that read: High Alert Double Check. The pharmacy label said 4 tablets were dispensed … ……. The medication box was empty. Fridays in … of 2022 on …, …, and … …. The MOR was documented that the medication had been given on …, 2, 3, 4, 5, 11,12,13, 14 and 16/22. Staff C said she could not explain why the box was empty or that the medication had been being given correctly. On … at 11:20 a.m., in a telephone call with the Pharmacist, she said the … was	A 056		

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A 056	Continued From page 17 dispensed on . . . . . and delivered to the facility on . She said on there should have been 3 tablets left if it was being given only every Friday. The Pharmacist said the high alert sticker on the box was to alert the nurse or med tech to pay attention that the dosage is only once a week. The Pharmacist explained if given too often it could cause , and other . . . . . irritations. Pharmacist said taking it every day it would be possible to overdose and cause many serious side effects. 3. On . . . . . at 3:30 p.m., Resident #3 said she has had many problems with her meds not being available. She said it happens over and over again. Resident #3 explained she had , caused by multiple conditions. She said she was not able to get her as needed (PRN) , medication the previous evening or on day of survey as it was not on and had to be ordered. She said her , medication had not been available at least 4 times and her regular medications once. She said the staff just kept saying they ordered it. On at 1:08 p.m., Surveyor and Staff A (med tech) compared the medications on for Resident #3 to her MOR. Resident #3's MOR revealed an order for , ... tablet (tab) 1 mg one tab by every 4 hours as needed for acute , . This medication was not available and Staff A said she had placed it on the Resident Care Coordinator desk to be reordered. The MOR was documented as not given on the evening of . . . . . . 4. On . . . . . at 1:08 p.m., Surveyor and Staff A (med tech) compared the medications on for Resident #4 to her MOR. Resident #4 MOR revealed an order for , tab 500 mg	A 056		

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A 056	Continued From page 18 take one tab by . . . . twice daily. This MOR was documented as not given at 8 p.m. on , and 8 a.m. on . . . . . . Staff A said the medication was not on and needed to be ordered. On . . . . . at 3:20 p.m., Resident #4 said she has had problems with her meds not being available. She said one time her . . . . , med was out for 5 days. She said she was not made aware her . . . . . , was out and said every time she gets her meds, it was a different person. 5. On at 3:47 p.m., Resident #5 said she was missing her , . . . medication and she was in horrible , . She said it had been out for a couple weeks. She said this happened one other time and she went 14 days without it, and then they said Oh I found it! On . . . . . at 3:55 p.m., Resident #5's MOR showed an order for , / tab 10-325 one tablet by . . . . every 4 hours as needed for non-acute , . This had not been given at all in . . . . . Staff A (med tech) said Resident #5 had asked for this medication earlier in the day, but the medication was not on , and she gave her , instead. Staff A said she let Staff C (Resident Care Coordinator) know it wasn't there. On at 5:15 p.m., the Administrator said she had recently taken over for the former Administrator and had not been aware of the problems occurring and would begin to formulate a plan to correct. Class II Photographic evidence obtained	A 056		

Agency for Health Care Administration

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A 000	Initial Comments An unannounced complaint survey for complaint #2021016128, #2022008129, #2022008877, #2022010275 and #2022011978 was conducted on .. ... through .. ... at Savannah Grand of Sarasota, an assisted living facility in Sarasota, Florida. Complaint #2021016128 was substantiated at A0054, A0056, A0093. Complaint #2022008129 was substantiated without deficient practice. Complaint #2022008877 was substantiated at A0093. Complaint #2022010275 was not substantiated. Complaint #2022011978 substantiated at A0054, A0056, A0030. The following is description of the deficiencies.	A 000		
A 081 SS=E	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation.	A 081		

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

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A 081	Continued From page 1 The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or	A 081		

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A 081	Continued From page 2 home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in [illegible] control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its [illegible] control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne [illegible], may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident [illegible], neglect, and [illegible]. The facility must use its [illegible] prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living.	A 081		

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A 081	Continued From page 3 (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure facility employees complete 2 hour preservice orientation prior to interacting with residents, and 1 hour of in-service training for safe food handling, Recognizing/Reporting /neglect and , as required by Florida Administrative Code within 30 days of employment for 8 (Staff A, B, C, G, H, I, and Administrator) of 10 employee files reviewed. The findings included: On at 12:20 p.m., observed staff B, C, and I assisting with serving the lunch meal to residents and preparing room trays to be delivered to residents. On , review of the facility employee list showed the administrator was hired on .	A 081		

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A 081	Continued From page 4 She received the promotion to Administrator on . Administrator's file contained no documented evidence of completing 2 hour preservice orientation prior to interacting with residents, nor 1 hour training for each of Safe Food Handling, and Recognizing/Reporting , Neglect and , . On , review of the facility employee list showed Staff A was hired on as a Resident aide/med tech. Staff A's file contained no documented evidence of completing 2 hour preservice orientation prior to interacting with residents, nor 1 hour training for each of Safe Food Handling, and Recognizing/Reporting , Neglect and , . On , review of the facility employee list showed the Staff B was hired on as a Resident aide/med tech. Staff B's file contained no documented evidence of completing 2 hour preservice orientation prior to interacting with residents, nor 1 hour training for each of Safe Food Handling, and Recognizing/Reporting , Neglect and , . On , review of the facility employee list showed the Staff C was hired on as a Resident Care Coordinator. Staff C's file contained no documented evidence of completing 2 hour preservice orientation prior to interacting with residents, nor 1 hour training for each of Safe Food Handling, and Recognizing/Reporting , Neglect and , . On , review of the facility employee list showed the Staff G was hired on as the Cook. Staff G's file contained no documented evidence of completing 2 hour preservice orientation prior to interacting with residents, nor	A 081		

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A 081	Continued From page 5 1 hour training for each of Safe Food Handling, and Recognizing/Reporting , Neglect and . On , review of the facility employee list showed the Staff H was hired on as a Resident aide/med tech. Staff H's file contained no documented evidence of completing 2 hour preservice orientation prior to interacting with residents, nor 1 hour training for each of Safe Food Handling, and Recognizing/Reporting , Neglect and . On , review of the facility employee list showed the Staff I was hired on as a Resident aide/med tech. Staff I's file contained no documented evidence of completing 2 hour preservice orientation prior to interacting with residents, nor 1 hour training for each of Safe Food Handling, and Recognizing/Reporting , Neglect and . On , review of the facility employee list showed the Staff J was hired on as a Resident aide/med tech. Staff J's file contained no documented evidence of completing 2 hour preservice orientation prior to interacting with residents, nor 1 hour training for each of Safe Food Handling, and Recognizing/Reporting , Neglect and . On at 3:22 p.m., the Administrator confirmed the findings.	A 081		
A 084 SS=E	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011 (6) ASSISTANCE WITH THE	A 084		

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A 084	Continued From page 6 SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, . , . . dosage	A 084		

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A 084	Continued From page 7 forms, and and dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with syringes that are prefilled with the proper dosage by a pharmacist and , that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection; i. Assist with ; j. Use a to perform testing; k. Assist residents with and continuous positive airway pressure (CPAP) devices, excluding the titration of the levels; l. Apply and remove stockings and hosiery; m. Placement and removal of , bags, excluding the removal of the or manipulation of the site; and, n. Measurement of , rate, temperature, and , rate. (c) Unlicensed persons, as defined in section	A 084		

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A 084	Continued From page 8 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure unlicensed persons who provide assistance with self-administration of medications complete an initial 6-hour training and annual 2-hour training on providing assistance with self-administered medications for 3 (Staff B, C, and F) of 6 employees reviewed.	A 084		

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A 084	Continued From page 9 The findings included: Record review of staff B's employee file revealed a hire date of [redacted] as a Resident Aide/Med Tech. Staff B's file contained no documented evidence of completing an initial 6-hour training for assistance with self-administration of medications. Record review of Staff C's employee file revealed a hire date of [redacted] as the Resident Care Coordinator. Staff C's file contained no documented evidence of completing 6 hours of continuing educations for assistance with self-administration of medications. Record review of Staff F's employee file revealed a hire date of [redacted] as a Resident Aide/Med Tech. Staff F's file contained documentation of completing 6 hours of continuing educations for assistance with self-administration of medications on [redacted], with documentation of completing annual 2-hour continuing education training for assistance with self-administration of medications on [redacted], and [redacted]. Staff F's file contained no further documented evidence of completion of annual 2-hour training for assistance with self-administration of medications as required. On [redacted] at 3:22 p.m., the Administrator confirmed the findings. Class III	A 084		
A 093 SS=F	59A-36.012(2) FAC Food Service - Dietary Standards	A 093		

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A 093	Continued From page 10 (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are incorporated by reference and available for review at: http://iom.edu/Activities/Nutrition/SummaryDRIs/~/media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%2014.pdf. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on	A 093		

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A 093	Continued From page 11	A 093		

the menus or on a separate sheet.
1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences.
2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents.
(d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months.
(e) Therapeutic diets must be prepared and served as ordered by the health care provider.
1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility.
2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal.
(f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2

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A 093	Continued From page 12 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to ensure the planned menus are posted and easily available to residents. The facility failed to follow menus completed and signed by the Registered Dietician (RD) to ensure the meals meet the current USDA dietary guidelines and the dietary reference intakes established by the Food and Nutrition Board of the Institute of Medicine. The facility failed to have menus reviewed and signed by a Registered Dietician annually with legible signature and date. The facility failed to maintain food substitution logs for last 6 months on file at the facility.	A 093		

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A 093	Continued From page 13 The findings included: On at 9:48 a.m., toured the facility including the dining room, and observed no menus were posted in the facility. On at 10:17 a.m., in an interview, Resident #9 said she has been at the facility since and the food is not nutritious and most times the meal is not the right combinations. The resident said there is never a menu posted and she does not know what is being served until coming to the dining room for the meal. On at 10:50 a.m., in an interview, Resident Care Director Staff D said he is filling in for the day to make the meals. Staff D stated they don't post the menus. He confirmed he did not post any menus. Staff D stated for the lunch meal today he will be serving baked chicken, cheesy potatoes, and mixed green vegetables. Dinner will be sloppy joes with a salad. Review of the diet spreadsheet revealed the lunch meal scheduled for as: hamburger on a , french fries, marinated slaw, bread pudding with vanilla sauce, and milk/beverage of choice. The signature and date on the diet spreadsheet were illegible and unable to be verified. On at 11:02 a.m., in an interview, Resident #6 said she has been at the facility for 6 years and it was good when she first moved in, now it's going downhill. She said the food is terrible. The resident said there are no menus posted so they can know what is being served. She said the residents only know what is being served when they sit down in the dining room and staff tell them the meal while taking the food order.	A 093		

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A 093	Continued From page 14 On at 12:16 p.m., reviewing the diet spreadsheet for therapeutic diets with the Administrator she said those are the menus they go by, and they choose what to serve day to day. On at 12:20 p.m., observation of the lunch meal noted the residents received chicken , mixed vegetables, cheesy potatoes, and fruit cocktail. Staff A, B, C, and E were serving the meals from the kitchen to the residents and helping to make plates for room trays and desserts. Staff A, B, and C do not have documented food handling training (see deficiency A 0081). On at 12:40 p.m., the Resident Care Director Staff D said when he prepared the lunch meal today he had no menus or recipes to go by and just made up the meal that was served from the items he found in the kitchen. On at 1:02 p.m., the Administrator stated they substituted the meal served for lunch today. When the food substitution logs for the last 6 months was requested, the Administrator provided copies of the resident meal preorder forms with no dates. The Administrator acknowledged the preorder forms are not a substitution log and confirmed there are no substitution logs on file. The Administrator reviewed the diet spreadsheet and confirmed the signature and date are illegible making it unverifiable when and by whom the spreadsheets were reviewed. On at 3:00 p.m., in an interview, Staff D confirmed he did not follow the menu that was provided to the facility by the dietician.	A 093		

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A 093	Continued From page 15 On . . . . . at 3:38 p.m., in an interview, Resident #10 said she has been at the facility for almost 1 year. She said they never post the menus for the meals, so they don't know what is being served until they sit in the dining room and staff then tell them what the meal is. On at 3:48 p.m., in an interview, Resident #11 said she has been at the facility for almost 1½ years and said they used to post the menus but they don't anymore. Now they don't know what meal is being served until sitting in the dining room. On . . . . . at 10:00 a.m., menus with legible signature and date by the dietician were requested from Administrator. The Administrator stated she has nothing further, what she provided is all she has. On . . . . . at 11:40 a.m., observed Caregiver Staff E in the dining room taking orders and informing residents of the lunch meal. Staff E confirmed the facility does not post menus and the residents are only informed of the meal when sitting in the dining room and staff take their orders. On . . . . . at 11:53 a.m., the cook Staff G stated that at meal time the staff tell the residents what is being served and take their orders. Staff G said, "they do not post the menu in the facility." On at 12:11 p.m., the Administrator confirmed there are no menus posted and acknowledged staff D did not follow the menu for the lunch and dinner meals prepared. She confirmed the facility has no substitution logs on file.	A 093		

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A 093	Continued From page 16 Class III Review of the resident order form revealed for the dinner meal on the residents received, sloppy joes, grilled cheese, salad, and fruit cocktail.	A 093		
A 200 SS=F	59A-36.025 FAC Emergency Environmental Control 59A-36.025 Emergency Environmental Control for Assisted Living Facilities. (1) DETAILED EMERGENCY ENVIRONMENTAL CONTROL PLAN. Each assisted living facility shall prepare a detailed plan ("plan") to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency environmental control in the event of the loss of primary electrical power in that assisted living facility which includes the following information: (a) The acquisition of a sufficient alternate power source such as a generator(s), maintained at the assisted living facility, to ensure that current licensees of assisted living facilities will be equipped to ensure air temperatures will be maintained at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. 1. The required temperature must be maintained in an area or areas, determined by the assisted living facility, of sufficient size to maintain residents safely at all times and that is appropriate for resident care needs and life safety requirements. For planning purposes, no less than twenty (20) net square per resident must be provided. The assisted living facility may use eighty percent (80%) of its licensed bed capacity as the number of residents to be used in the to determine the required square	A 200		

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footage. This may include areas that are less than the entire assisted living facility if the assisted living facility's comprehensive emergency management plan includes allowing a resident to congregate when he or she desires in portions of the building where temperatures will be maintained and includes procedures for monitoring residents for signs of heat related injury as required by this rule. This rule does not prohibit a facility from acting as a receiving provider for evacuees when the conditions stated in section 408.821, F.S. and subsection 59A-36.019(5), F.A.C., are met. The plan shall include information regarding the area(s) within the assisted living facility where the required temperature will be maintained.
2. The alternate power source and fuel supply shall be located in an area(s) in accordance with local zoning and the Florida Building Code.
3. Each assisted living facility is unique in size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and staffing characteristics. Accordingly, this rule does not limit the types of systems or equipment that may be used to achieve temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. The plan shall include information regarding the systems and equipment that will be used by the assisted living facility and the fuel required to operate the systems and equipment.
a. An assisted living facility in an evacuation zone pursuant to chapter 252, F, S. must maintain an alternative power source and fuel as required by this subsection at all times when the assisted living facility is occupied but is permitted to utilize a mobile generator(s) to enable portability if

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A 200	Continued From page 18 evacuation is necessary. b. Assisted living facilities located on a single campus with other facilities under common ownership, may share fuel, alternative power resources, and resident space available on the campus if such resources are sufficient to support the requirements of each facility's residents, as specified in this rule. Details regarding how resources will be shared and any necessary movement of residents must be clearly described in the emergency power plan. c. A multistory facility, whose comprehensive emergency management plan is to move residents to a higher floor during a flood or surge event, must place its alternative power source and all necessary additional equipment so it can safely operate in a location protected from flooding or storm surge damage. (b) The acquisition of sufficient fuel, and safe maintenance of that fuel at the facility, to ensure that in the event of the loss of primary electrical power there is sufficient fuel available for the alternate power source to maintain . . . . temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours after the loss of primary electrical power during a declared state of emergency. The plan must include information regarding fuel source and fuel storage. 1. Facilities must store minimum amounts of fuel onsite as follows: a. A facility with a licensed capacity of 16 beds or less must store 48 hours of fuel onsite. b. A facility with a licensed capacity of 17 or more beds must store 72 hours of fuel onsite. 2. An assisted living facility located in an area in a declared state of emergency area pursuant to section 252.36, F.S. that may impact primary power delivery must secure ninety-six (96) hours	A 200		

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A 200	Continued From page 19 of fuel. The assisted living facility may utilize portable fuel storage containers for the remaining fuel necessary for ninety-six (96) hours during the period of a declared state of emergency. 3. Piped natural gas is an allowable fuel source and meets the onsite fuel supply requirements under this rule. 4. If local ordinances or other regulations limit the amount of onsite fuel storage for the assisted living facility's location, then the assisted living facility must develop a plan that includes maximum onsite fuel storage allowable by the ordinance or regulation and a reliable method to obtain the maximum additional fuel at least 24 hours prior to depletion of onsite fuel. (c) The acquisition of services necessary to maintain, and test the equipment and its functions to ensure the safe and sufficient operation of the alternate power source maintained at the assisted living facility. (d) The acquisition and maintenance of a . . . . monoxide alarm. (2) SUBMISSION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall submit its plan to the local emergency management agency for review within 30 days of the effective date of this rule. Assisted living facility plans previously submitted and approved pursuant to emergency Rule 58AER17-1 will require resubmission only if changes are made to the plan. (b) Each new assisted living facility shall submit the plan required under this rule prior to obtaining a license. (c) Each existing assisted living facility that undergoes any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of its systems or equipment affecting the facility's	A 200		

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compliance with this rule shall amend its plan and submit it to the local emergency management agency for review and approval.
(3) APPROVED PLANS.
(a) Each assisted living facility must maintain a copy of its approved plan in a manner that makes the plan readily available at the licensee's physical address for review by a legally authorized entity. If the plan is maintained in an electronic format, assisted living facility staff must be readily available to access and produce the plan. For purposes of this section, "readily available" means the ability to immediately produce the plan, either in electronic or paper format, upon request.
(b) Within two (2) business days of the approval of the plan from the local emergency management agency, the assisted living facility shall submit in writing proof of the approval to the Agency for Health Care Administration.
(c) The assisted living facility shall submit a consumer-friendly summary of the emergency power plan to the Agency. The Agency shall post the summary and notice of the approval and implementation of the assisted living facility emergency power plans on its website within ten (10) business days of the plan's approval by the local emergency management agency and update within ten (10) business days of implementation.
(4) IMPLEMENTATION OF THE PLAN.
(a) Each assisted living facility licensed prior to the effective date of this rule shall, no later than , have implemented the plan required under this rule.
(b) The Agency shall allow an extension up to to providers in compliance with paragraph (c) below and who can show delays caused by necessary construction, delivery of

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	AL11953679	A. BUILDING: _____ B. WING _____	08/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH GRAND OF SARASOTA	7130 BENEVA ROAD SARASOTA, FL 34238

(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 200	Continued From page 21 ordered equipment, zoning or other regulatory approval processes. Assisted living facilities shall notify the Agency that they will utilize the extension and keep the Agency apprised of progress on a quarterly basis to ensure there are no unnecessary delays. If an assisted living facility can show in its quarterly progress reports that unavoidable delays caused by necessary construction, delivery of ordered equipment, zoning or other regulatory approval processes will occur beyond the initial extension date, the assisted living facility may request a waiver pursuant to section 120.542, F.S. (c) During the extension period, an assisted living facility must make arrangements pending full implementation of its plan that provides the residents with an area or areas to congregate that meets the safe indoor air temperature requirements of subsection (1) (a) for a minimum of ninety-six (96) hours. 1. An assisted living facility not located in an evacuation zone must either have an alternative power source onsite or have a contract in place for delivery of an alternative power source and fuel when requested. Within twenty-four (24) hours of the issuance of a state of emergency for an event that may impact primary power delivery for the area of the assisted living facility, it must have the alternative power source and no less than ninety-six (96) hours of fuel stored onsite. 2. An assisted living facility located in an evacuation zone pursuant to chapter 252, F.S. must either: a. Fully and safely evacuate its residents prior to the arrival of the event; or b. Have an alternative power source and no less than ninety-six (96) hours of fuel stored onsite, within twenty-four (24) hours of the issuance of a state of emergency for the area of the assisted	A 200		

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A 200	Continued From page 22 living facility. (d) Each new assisted living facility shall implement the plan required under this rule prior to obtaining a license. (e) Existing assisted living facilities that undergo any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of the systems or equipment affecting the assisted living facility's compliance with this rule shall implement its amended plan concurrent with any such additions, modifications, alterations, refurbishment, renovations or reconstruction. (f) The Agency for Health Care Administration may request cooperation from the State Fire Marshal to conduct inspections to ensure implementation of the plan in compliance with this rule. (5) POLICIES AND PROCEDURES. (a) Each assisted living facility shall develop and implement written policies and procedures to ensure that the assisted living facility can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. The procedures shall ensure that residents do not experience complications from fluctuations in air temperatures inside the facility. Procedures must address the care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury including: 1. The use of cooling devices and equipment; 2. The use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration; 3. Wellness checks by assisted living facility staff to monitor for signs of and heat	A 200		

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A 200	Continued From page 23 injury; and 4. A provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy. (b) Each assisted living facility shall maintain the written policies and procedures in a manner that makes them readily available at the licensee's physical address for review by a legally authorized entity. If the policies and procedures are maintained in an electronic format, assisted living facility staff must be readily available to access the policies and procedures and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce the policies and procedures, either in electronic or paper format, upon request. (c) The written policies and procedures must be readily available for inspection by each resident; each resident's legal representative, designee, surrogate, guardian, attorney in fact, or case manager; each resident's estate; and such additional parties as authorized in writing or by law. (6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this rule, the Agency for Health Care Administration may seek any remedy authorized by chapter 429, part I, or chapter 408, part II, F.S., including, but not limited to, license revocation, license suspension, and the imposition of administrative fines. (7) COMPREHENSIVE EMERGENCY MANAGEMENT PLAN. (a) Assisted living facilities whose comprehensive emergency management plan is to evacuate must comply with this rule. (b) Each facility whose plan has been approved shall submit the plan as an addendum with any future submissions for approval of its	A 200		

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A 200	Continued From page 24 comprehensive emergency management plan. (8) NOTIFICATION. (a) Within five (5) business days, each assisted living facility must notify in writing, unless permission for electronic communication has been granted, each resident and the resident's legal representative: 1. Upon submission of the plan to the local emergency management agency that the plan has been submitted for review and approval; 2. Upon final implementation of the plan by the assisted living facility. (b) Each assisted living facility must maintain a copy of each notification set forth in paragraph (a) above in a manner that makes each notification readily available at the licensee's physical address for review by a legally authorized entity. If the notifications are maintained in an electronic format, facility staff must be readily available to access and produce the notifications. For purposes of this section, "readily available" means the ability to immediately produce the notifications, either in electronic or paper format, upon request. This Statute or Rule is not met as evidenced by: Based on record review and staff interview the facility failed to ensure completion and maintain documentation of an approved Emergency Power Plan on file at the facility. The facility failed to ensure there was enough fuel onsite to run the onsite generators for 72 hours in an emergency. The findings included: On request was made to the administrator for documentation of a County Emergency Management Plan (CEMP) and Emergency Power Plan (EPP) with approval letter.	A 200		

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A 200	Continued From page 25 On at 10:15 a.m., the facilities generators were observed in an enclosed shed next the building. There were 4 generators and 6 35-gallon gas caddies full of gasoline totaling 140 gallons stored onsite. Two other gas caddies were empty of fuel. According to the website: https://www.generac.com/generaccorporate/media/library/content/all-products/portable-recreational-power, the GP 5500 model generator has a fuel capacity of 7.2 gallons and can run for 10 hours. This would mean the facility has to store 400 gallons of fuel on site. On at 10:25 a.m., the maintenance Director confirmed the facility does not have adequate fuel onsite for the generators. On at 11:30 a.m., the Administrator acknowledged the facility does not have enough fuel onsite to power the alternate power source for 72 hours as required. On at 12:30 p.m., Administrator provided documentation of the CEMP with approval letter dated , there was no documentation of EPP included. The Administrator stated she has no documentation of the EPP on file at the facility. Class III	A 200		