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
	AL11969444	A. BUILDING: _____ B. WING _____	R 08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA AT PARKSQUARE (THE)	2940 NE 207 STREET AVENTURA, FL 33180

(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 Amended A Revisit to a Complaint Investigation (complaints # 2022005161 and 2022009263) at Plaza at Parksquare (the) on [redacted] 29, 2022 through [redacted] 31, 2022. Deficiencies were identified at the time of the survey	{A 000}		
{A 010} SS=G	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual	{A 010}		

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{A 010}	Continued From page 1 receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of	{A 010}		

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{A 010}	Continued From page 2 Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a , may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a	{A 010}		

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{A 010}	Continued From page 3 plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their	{A 010}		

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{A 010}	Continued From page 4	{A 010}		

professional licensure or training.
(g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C.

This Statute or Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure the appropriateness of continued residency for one out of 119 sampled residents (Resident # 33). The resident, who left the facility without staff's knowledge of her whereabouts, was hospitalized after she left a second time and was found in the street.

Findings include:

A review of an incident report revealed, "On , a food service director reported that he was coming to work at approximately 5:45 AM; he noted a private duty aide [PDA] with one of the community residents near [local restaurant]. The resident was brought to the community immediately at approximately 5:48 AM by the food director and PDA (private duty aide). The resident had no injuries."

During an interview on at 10:01 AM, the food service director, Staff R, stated, "it was about two weeks ago on a Sunday or Monday. I was coming off the parking garage when I saw the resident standing and talking with the PDA. She appeared and did not know her last name when asked. She did not know where she was."

During an interview on at 11:51 AM with the private duty aide [PDA] that found Resident #33, she stated, "She was walking in her nightgown. Staff and I brought her in at 5:30 AM. They (staff) did not know she was missing. One

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{A 010}	Continued From page 5 of the nurses said they saw her in bed about half an hour ago. [Resident #33] was and did not know where she was. She said that she was trying to find her room." During an interview on at 10:21 AM about the elopement on , corporate staff, Staff AE, stated, "We got her a private duty aide paid for by the facility to provide extra supervision, 24/7, care until she moved to the memory care unit." A review of Resident #33's record revealed she was moved to the memory care unit on . A review of Resident #33's health assessment dated revealed a medical history and diagnoses of without behavioral disturbance, , and a history of . Resident #33 had physical limitations of occasional unsteady gait, uses a walker to ambulate, and status of . Resident #33 had nursing requirements of the memory care unit and precautions and was identified as an elopement risk. The resident was independent with ambulation, eating, toileting, and transferring, needed supervision with bathing and grooming, and needed assistance with self-administration of medication. During an interview on at 7:20 AM, Front Desk Receptionist Staff AI stated, " When I first started, she {Resident #33} would always try to leave the building." When asked did she tell anyone, she stated, "Yes, I told them. I was new. I started on .". A review of Resident #33's health assessment dated revealed a medical history and diagnoses of without behavioral	{A 010}		

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{A 010}	Continued From page 6 disturbance and . The or behavioral status section showed the resident had a moderate . Resident #33 was identified as not at risk for elopement. The resident needed assistance with the self-administration of medication. A review of facility records revealed an incident report dated , which showed that Resident #33 went through the front door (lobby) and went on the busy street. Then, a staff member went after the resident and caught her at the time when Resident #33 was stepping right into a moving car. Uncorrected Class III	{A 010}		
{A 025} SS=H	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	{A 025}		

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{A 025}	Continued From page 7 appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's 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 record review and interview, the facility failed to provide adequate supervision as	{A 025}		

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{A 025}	Continued From page 8	{A 025}		

appropriate for each resident to ensure awareness of the general health, safety, physical and emotional well-being for 9 out of 119 sampled residents (Residents #10,12, 26, 33, 35, 39, 42, 76, 79). Resident #26 . . , hitting her . . . on the pavement after . from the facility. Resident #33 was found near a restaurant nearby after having eloped. Resident #12 sustained a right ring phalanx . . . . . and a right . . . . . of the right anterior wall . . Resident #35 suffered a superficial . . . . on the right lower . after a . Residents #42 and #76 sustained . . . . . at multiple places on their bodies, and Resident# 79 was transferred to the hospital after falling at the facility.

Findings include:

A review of the adverse incident report filed on . showed at approximately 5:30 AM, Resident #33 left the facility using the stairs on the 5th floor. The resident was seen by a private duty aide and the food service director outside the community. At 5:48 AM, the resident was brought . . . to her room. The resident had no injuries.

During an interview on . . . . . at 10:01 AM, the food service director, Staff R, stated, "It was about two weeks ago on a Sunday or Monday. I was coming off the parking garage when I saw the resident standing and talking with the PDA (Private Duty Aide). She appeared to be . . . and did not know her last name when asked. She did not know where she was."

During an interview on . at 11:51 AM with the private duty aide that found Resident #33, she stated, "She was walking in her nightgown. Staff and I brought her in at 5:30 AM. They (staff) did not know she was missing. One

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{A 025}	Continued From page 9 of the nurses said they saw her in bed about half an hour ago. [Resident #33] was and did not know where she was. She said that she was trying to find her room." A review of Resident #33's health assessment dated showed a medical history and diagnoses of without behavioral disturbance, , and a history of . The resident was independent with ambulation, eating, toileting, and transferring, and needed supervision with bathing and grooming. The resident was identified as an elopement risk. During an interview on at 10:21 AM, when asked about Resident #33's elopement, corporate staff, Staff AE stated, "I called the son, and he said 'yeah this had happened in the past when the previous administrator called me and told me that my mom tried to elope she told me that she would call me when the facility had an opening in the memory care unit.'" During an interview on at 7:20 AM, Front Desk Receptionist Staff AI stated, "When I first started, she (Resident #33) would always try to leave the building." A review of Resident #33's progress notes revealed that on , the resident left the facility through the front door onto a busy street. A review of the agency's adverse incident database showed no incident report was filed for Resident #33's first elopement. A review of Resident #33's records showed no documentation of the resident being reassessed after the first elopement. Further review showed	{A 025}		

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{A 025}	Continued From page 10 no documentation that the facility contacted the resident's physician about Resident #33's attempts to elope and to seek guidance on preventing other occurrences. 2) A review of the adverse incident report filed on [redacted] showed on [redacted], Resident #26 was seen outside the facility by a private duty aide. The aide then alerted the front desk receptionist. Two caregiving staff went outside to escort Resident #26 [redacted] into the building; however, she refused. As she tried to walk away, the resident [redacted], hitting her [redacted]. Staff got Resident #26 up from the ground and escorted her [redacted] into the facility. A review of the facility's incident report dated [redacted] showed, "Receptionist and staff notified staff that resident was outside and didn't want to come in. Shortly, staff tried to encourage the resident to come in; she refused and slipped and [redacted] and hit her [redacted] on the sidewalk." Further review of the facility's incident report showed that staff AH, front desk receptionist annotated, "Around 1 PM I saw her [Resident #26] walk around the 1st floor like she usually does. At about 1:3 PM, [[redacted] 's PDA] came [redacted] into the building from buying lunch and alerted me that she saw [Resident #26] walking around by [local restaurant]. I walked [redacted] and exited through the side door to go get her but didn't see her. When I returned to the front desk, one of the staff members walked [redacted] with [Resident 26] to the building. Every attempt I made to persuade to make her come [redacted] into the building, she refused. The resident then began walking away from the building towards [hotel].	{A 025}		

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{A 025}	Continued From page 11 A review of the facility's post- policy and procedures showed if the resident had a injury, the staff was to call 911. A review of Resident #26's progress notes showed no notation that 911 was called or if there was any follow-up care with the resident's health care provider. During an interview on at 9:53 AM, corporate staff, Staff AE, stated, "On , the staff told me that the resident left the community. They followed her out, and out there, she . She was outside by herself at 1 PM. I called the daughter and said she had a scrape and needed to go to the hospital; the daughter said absolutely not. [Staff B] tried to clean her, and the resident refused, and the daughter refused to send her out to the hospital." A review of Resident #26's progress notes dated showed, "Once again, the resident daughter was contacted regarding sending to the hospital, and she refused. The staff states resident had on the and area. Staff asked the daughter if we were able to do an , and she stated it was not necessary." During an interview on at 9:30 AM, the Director of Resident Care stated, "On , I went to talk to her [Resident #26] and try and do an assessment, she told me to get the hell away, and there's nothing I can do for her, I was only able to see her , and I saw a small scrape, she wouldn't allow us to her assess her. On , the resident finally allowed them to do ." During an interview on at 11:13 AM, when asked what precautions were implemented	{A 025}		

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{A 025}	Continued From page 12 after the elopement, the Director of Resident Care stated, "Extra insight was implemented. We checked with the front desk to see if they saw the resident or kept an , on her, which was in place until they would get a sitter or aide. There is no documentation of this." A review of Resident #26's progress notes dated showed, "At 1:15 PM, resident was observed attempting to walk out of building, unaccompanied." During an interview on at 10:40 AM, corporate staff, Staff AE, stated, "They said [Resident #26] went outside and the Staff F ran after her 20 seconds later, the staff followed her, the resident was letting go of her walker, and four staff were around her, and the resident was trying to hit the staff. I came around her and tried to calm her down; the resident scratched me and started hitting me." A review of second progress notes dated showed, "[Resident #26] appeared to be very and refused to be redirected. 911 was called to provide police to send the resident out on . While waiting for the police, the nephew arrived and attempted to take the resident home with him. The resident refused and walked away. Police and fire rescue arrived, and the resident was transferred to the [hospital]." A review of the hospital record received on showed a "female with a history of advanced presents by (emergency medical services) from the ALF (Assisted Living Facility) under by police for aggressive behavior. The patient was refusing medications at the facility and into the road, according to the report. The	{A 025}		

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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 025}	Continued From page 13 patient cannot remember what happened today or why she is here." A review of Resident #26's health assessment dated ..... showed a medical history and diagnoses of , , , history of , and . The resident was independent with ambulation, eating, and transferring and needed assistance with bathing, , grooming, and toileting. The resident had precautions and was identified as an elopement risk. 3) A review of the facility's incident report dated ..... showed at 11:35 AM, Resident #10 was found lying down on the floor in her room. A review of Resident #10's progress notes dated ..... showed, Staff went to check on the resident during rounds and noted the resident was lying on the floor. The resident was not noted in any distress or at this time." A review of a second facility incident report dated ..... showed, "Found resident on the floor in her bathroom in a sitting position. No were noted. The resident was helped from the floor and placed comfortably in her bed." In an interview on at 11:43 AM, when asked whether Resident #10 had before , the Director of Resident Care stated, "[Resident #10] had a before this month; she had one in ." A review of the facility's incident log revealed that Resident #10 three times from months through . A review of Resident #10's health assessment	{A 025}		

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{A 025}	Continued From page 14 dated . . . . . showed medical diagnoses and a history of . . . . . Type 2, and . . . . . . The resident needed supervision with grooming and toileting and assistance with ambulation, bathing, , and transferring. The health assessment indicated that the resident needed precautions. On at 11:53 AM, when asked what measures were put in place to prevent Resident #10's , the Director of Resident Care stated, "Lower the bed to the floor since she likes to get out of bed; she has side rails, they keep better . . on her to make sure she is engaged in activities." A review of Resident #10's record showed no documentation of the preventive measures in place at the time of the resident's . During an interview with the Director of Resident Care on . . . . . at 11:54 AM, when asked for documentation of precautions taken for Resident #10, she stated, "This is not documented." 4) A review of the adverse incident report filed on . . . . . showed Resident #12 was walking around the common area, lost her balance, and . . A review of the facility's incident report dated showed at 4:19 PM, "Resident was walking in the TV area, she turned to go the other direction and to the floor. The resident on her right side; she has a . . . . . on her right cheek. 911 was called. The resident was transported to the hospital."	{A 025}		

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{A 025}	Continued From page 15 In an interview on at 1:20 PM, MedTech (medication technician) (medication technician) (medication technician) (medication technician) (medication technician) (medication technician) Staff U stated, "[Resident #12] was walking alone on the memory care unit and . Her PDA (private duty aide) was gone; her PDA usually walked up and down with her, but at the time of the , the PDA was not on duty." A review of Resident #12's health assessment dated showed medical diagnoses and a history of , and D deficiency. The resident needed supervision with transferring, assistance with ambulation, eating, and total care with bathing, , self-care, and toileting. The health assessment indicated that the resident needed precautions. On at 11:36 AM, Staff AE stated, "When the resident was turning from walking down the hall and forth, and when she went to turn, she lost her balance and . They noted that she had a on the right cheek. They called 911, and the next day the son called to say she had a ." A review of hospital record received on showed a 'History of Present illness' of "female presenting to the ED (emergency department) chief complaint of slip and with open right cheek , right open nondisplaced of right anterior wall , and right ring nondisplaced extra- phalanx ." On at 11:47 AM, when asked if this was Resident #12's first , the Director of	{A 025}		

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{A 025}	Continued From page 16 Resident Care stated, "That was the only that I was aware of." Corporate Staff AE then inputted, "There's no documentation of the in the record. The first documented in the record was in . Before the incident, reports were everywhere." 5) A review of the facility's incident report dated at 11:45 PM showed, "Received a phone call to bring a bandage to room. [Resident #35] stated she had . Upon arriving at her room, I found her sitting on the bathroom commode with a on her right lower ." A review of Resident #35's progress notes dated showed, "Home health treating superficial right lower . Healing without issues. Resident states she hit her on her walker when she ." A review of Resident #35's health assessment dated showed medical diagnoses and a history of decline, , and . The resident needed assistance with ambulation, bathing, , grooming, toileting, and transferring. The health assessment indicated that the resident needed precautions. A review of the facility's incident log revealed that Resident #35 also on . A review of Resident #35's record showed no documentation of the preventive measures at the time of the resident's . 6) A review of the facility's incident report dated	{A 025}		

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{A 025}	Continued From page 17 showed at 7:35 PM, "[Resident #39] state she was putting the chicken in refrigerator lost her balance and . Complain of no , and no was visible." A review of the facility's incident log revealed that Resident #39 also on . A review of Resident #39's record showed no documentation of the preventive measures at the time of the resident's . A review of Resident #39's health assessment dated showed medical diagnoses and a history of , , , , type II, and , . The resident needs assistance with ambulation, bathing, and . The health assessment indicated that the resident needed precautions. 7) A review of the facility's incident report dated at 11:45 PM showed that Resident #42 visited the home health office and informed them that he were noted on arms. Staff cleaned and dressed the . A review of Resident #42's progress notes dated showed, "Resident was interviewed on what occurred; he stated that he in the shower but that he is doing good and has no , at this time." A review of the facility's incident log revealed that Resident #42 also on . A review of Resident #42's record showed no documentation of the preventive measures at the time of the resident's .	{A 025}		

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{A 025}	Continued From page 18 A review of Resident #42's health assessment dated showed medical diagnoses and a history of , prostatic hyperplasia, , and . The resident was independent with ambulation, bathing, , grooming, toileting, and transferring. The health assessment indicated that the resident had no precautions. A review of Resident #42's records showed no documentation of an updated health assessment after the resident's . 8) A review of the facility's incident log revealed that Resident #76 two times from months through . A review of the facility's incident report dated at 11:45 PM showed, "[Resident #76] was trying to get out of the wheelchair and . He has a on his left lower arm. The resident was offered to go to the hospital, but he refused. Resident states no at this time." A review of Resident #76's progress notes dated showed, "Resident's PDA (private duty aide) used pendant call and was found sitting on the floor. He denies any and refuses to be checked at this time. The resident was helped off the floor by PDA and a staff member. 911 was called. The resident refused to be checked." A review of a second incident report dated showed at 8:45 PM, Resident #76's PDA contacted staff for help stating that the resident was agitated and that when he tried to leave, he . Staff noted that the resident had no	{A 025}		

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{A 025}	Continued From page 19 injuries. 911 was called; however, the resident refused to be checked. A review of Resident #76's record showed no documentation of the preventive measures in place at the time of the resident's . A review of Resident #76's health assessment dated showed medical diagnoses and a history of , , , , , , and . The resident needed precautions. The activities of daily living portion of the health assessment were not in the file. 8) A review of the facility's incident report dated showed at 2:40 PM, "Resident stated that she in her room. She complains of no , and has no . Upon investigation, the resident while attempting to reach for her walker." On at 5:09 AM, when asked if there were any residents in the hospital, Staff N, MedTech (medication technician) (medication technician) (medication technician) (medication technician), stated, "[Resident #79] went to the hospital yesterday because she ." A review of the facility's post- policy and procedures showed the facility "document any information about the incident in the resident's service notes." A review of Resident #79's progress notes showed no documentation of the resident's . During an interview on at 6:52 AM, Staff N stated, "The resident called the front desk.	{A 025}		

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{A 025}	Continued From page 20	{A 025}		

She said she called the wellness office on the phone, but we never received it. The front desk called us and said that [Resident #79] she said she . When we got there, she was seated on the recliner chair with an ice pack over her . Her son came and called 911. When 911 arrived, they just took her to the emergency room. "

A review of the hospital record received on showed a 'History of Present Illness' of showed "patient is a female that presents to the ED (emergency department) prior to arrival. Per (emergency medical services) patient hit her against the side of the nightstand with no loss of . She is complaining of , over the , ."

A review of the facility's incident log revealed that Resident #79 three times from months through .

In an interview with Staff N on at 5:35 AM, Staff N stated, "We tried to get her a PDA, but she doesn't want one. She says she does not want to pay someone to sit there and do nothing. That's why she keeps on falling and falling."

A review of Resident #79's record showed no documentation of the preventive measures at the time of the resident's .

A review of Resident #79's health assessment dated showed medical diagnoses and a history of , and Automatic -defibrillator placement. The resident needs supervision with ambulation, bathing, , toileting, and transferring. The health assessment indicated that the resident had

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{A 025}	Continued From page 21 no precautions. A review of Resident #79's records showed no documentation of an updated health assessment after the resident's . . . Uncorrected Class II	{A 025}		
A 027 SS=H	59A-36.007(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making . , and remind residents about scheduled . . . . for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation. (c) The facility may not require residents to receive services from a , health care provider. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to assist with the arrangement of healthcare services for one out of 119 sampled residents (Resident #26). Resident #26 , hit her , did not receive any medical attention until two days later, and did not go to the hospital until seven days later after exhibiting behavior changed. Findings included:	A 027		

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A 027	Continued From page 22 Review of facility's incident report dated [redacted] showed, "Resident #26 was seen outside of the facility by a private duty aide (PDA). The PDA went up and reported the resident outside to the front desk. The front desk called Staff AG, Direct Caregiver, and she (Staff AG) went outside to attend to the resident. Another caregiver [Staff F] was called as well and came out to assist Staff AG. Together along with the PDA, they got the resident up off the ground and took her to safety within the confines of the community." On [redacted] at 09:30 AM, during an interview with Director of Resident Care regarding Resident #26, she stated, "On [redacted] resident was outside by the end of the walkway, they wanted her to come in cause it was hot outside, they tried to turn the walker and while they were doing that she turned, took one [redacted] off to push the staff and slipped. I was only able to see her [redacted], and I saw a small scrape; she wouldn't allow us to assess her." When asked what happened to Resident #26 on [redacted], Director of Resident Care then stated, "I don't know what happened, I wasn't involved in this." On [redacted] at 09:45 AM, Staff AG stated, "I was going downstairs, and valet called me. I went down and saw Staff AH from the front desk with the staff. She was laid down on her [redacted], she didn't [redacted] she was just like laying down to the floor with her walker next to her. She wasn't hurt and she had no [redacted]. I just help her to get up and come in. The other staff [Staff F] and a PDA helped." Review of Resident #26's progress notes revealed that Resident #26 did not receive	A 027		

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A 027	Continued From page 23	A 027		

medical attention until two days later, on . Resident #26 did not see a medical professional until . Resident #26 did not receive medical care until after the resident displayed some aggressive behaviors towards staff and taken to the hospital by police, under the :

- "Resident #26 was seen by staff members walking outside. Resident was not ready to come in, staff tried to encourage her to come in (getting hot). She turned and flipped her , refused staff to assist or exam her."

- " ... Staff states resident had on and area ... Resident #26 states she is but not in ."

- "This evening Resident was very agitated. Resident daughter contacted staff stating she is consenting , at this time. Mobile company came to facility, resident only allowed , at this time."

- " , results returned normal limits at this time. Resident is not complaining of , at this time."

- "Resident has been seen as follow up by PCP (Primary care physician)."

- "Resident had an elopement assessment form which resulted in the resident being added to the elopement list."

- "Resident was observed attempting to walk out of building, unaccompanied. Staff walked with resident, then resident became aggressive with staff and attempted to hit staff member. Then resident attempted to hit a staff member then grabbed and scratched another staff member. Continued to walk away yelling and walked out of the doors Staff followed behind resident. Resident appeared to be very and refused to be redirected... 911 was called, to provide to police to send resident out on ... Police and fire rescue arrived

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A 027	Continued From page 24 resident was transferred to local hospital." On . . . . . at 10:40 AM, interview with Staff AE, Corporate Staff, regarding Resident #26's count of events, Staff AE stated, "On . . . . . she was outside by herself at PM she was seen in the lobby, at 1:30 PM [PDA] came in and said that Resident was behind the building. The receptionist [Staff AH] walked . . . there but didn't see her. So, she walked towards the front, and she saw the resident with another staff member walking. She refused to come inside, I attempted to get her . . . . in, the resident began walking towards the opposite way, the valet called a CNA for help, [Staff AG] came, the resident tried to walk without her walker, and she scraped her . and her . . . on the sidewalk, [Staff F and PDA] came, and she was finally able to be brought . . . . inside." When asked how Resident #26 got scrapped, Staff AE stated that Resident #26 . . and hit her . . . on the sidewalk. When asked what the policy was for when a resident . and hit their . . , Staff AE stated, "Per the policy, we are to call 911 for any . . . injury. I don't know if they called." Staff AE further stated, "On . . . . . she was seen by the doctor. On in the morning, I saw the resident and a gentleman lab member attempting to do work, the resident was not allowing him to complete the . . . . work or specimen withdrawal. I attempted to redirect her, the resident said she doesn't believe it. The resident was assessed as an elopement risk. At 01:50 PM they said Resident #26 went outside, and Staff F ran after her 20 seconds later. The staff followed her; the resident was letting go of her walker, 4 staff were around her, and the resident was trying to hit the staff. I came around her and tried to calm her down, the resident	A 027		

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A 027	Continued From page 25 scratched me and started hitting me." Review of Resident #26's hospital record dated showed, " female with a history of advanced 's presents by from the ALF under by police for aggressive behavior. Patient was refusing medications at the facility and into the road according to report. Patient cannot remember what happened today or why she is here." Review of Resident #26's health assessment completed on showed medical history and diagnoses of , , Hex (history) of , ; the resident was on precautions and elopement risk. For activities of daily living, the resident was independent with ambulation, eating, transferring, and needed assistance with bathing, , grooming, and tilting. The resident also needed assistance with self-administration of medications. Class II	A 027		
{A 032} SS=E	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 for risk of elopement by a health care provider or	{A 032}		

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{A 032}	Continued From page 26	{A 032}		

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 implementing each part of the elopement

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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 032}	Continued From page 27 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 record review and interview, the facility failed to follow its policies and procedures regarding elopement after two out of 119 sampled residents (Residents #33 and #26) left the facility without staff knowledge. Resident #33 had a history of elopement, and no interventions were implemented to prevent the occurrence from happening at the facility. Findings included: A review of Resident #33's health assessment completed on revealed a medical history and diagnoses of without behavioral disturbance, , and a history of . Resident #33 had physical limitations of occasional unsteady gait, uses walker to ambulate and a status of . Resident #33 had nursing requirements of memory care unit, precautions, and was identified as an elopement risk. The resident was independent with ambulation, eating, toileting, and transferring, needed supervision with bathing and grooming and needed assistance with self-administration of	{A 032}		

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	AL11969444	A. BUILDING: _____ B. WING _____	R 08/31/2022

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{A 032}	Continued From page 28 medication. Review of an incident report revealed "On . . . a food service director reported that he was coming to work at approximately 5:45 am, he noted a private duty aide [PDA] with one of the community residents near [local restaurant]. Resident was brought to community immediately at approximately 5:48 am by food director and PDA. Resident had no injuries." During an interview on at 10:01 AM the food service director, Staff R, stated "it was about two weeks ago on a Sunday or Monday. I was coming off the parking garage when I saw the resident standing and talking with the PDA. She appeared to be . . . . . and did not know her last name when asked. She did not know where she was." During an interview on . . . . . at 11:51 AM with the private duty aide [PDA] that found Resident #33 they stated "She was walking in her night gown. A staff and I brought her in at 5:30 AM. They (staff) did not know she was missing. One of the nurses stated that they saw her about a half an hour ago in bed. [Resident #33] was and did not know here she was. She said that she was trying to find her room." During an interview on . . . . . at 10:21 AM about the elopement on corporate staff, Staff AE, stated "I called the son and he said 'yeah this has happened in the past, when the previous administrator called me and told me that my mom tried to elope she told me that she would call me when the facility had an opening in the memory care unit.'" During an interview on at 10:29 AM	{A 032}		

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{A 032}	Continued From page 29 when asked what interventions were put into place to prevent further elopement corporate staff, Staff AE, stated "The facility's intervention was to hire an outside PDA for 24 hours which the facility paid for." During an interview on [redacted] at 7:20 AM, Front Desk Receptionist Staff AI, stated that" When I first started, she (Resident #33) would always try to leave the building." When asked did you tell anyone she stated "Yes, I told them. I was new. I started on [redacted] ". A review of facility records revealed an incident report dated [redacted], which showed that Resident #33 went through the front door (lobby) and went on the busy street. Then, a staff member went after the resident and caught her at the time when Resident #33 was stepping right into a moving car. Further review of the resident's record revealed there was no documentation that the resident received a medical evaluation or care prior to Resident #33's second elopement. There was no documentation of an updated health assessment. There were no documented elopement precautions put in place for the resident. A review of Resident #33's health assessment completed on [redacted] revealed a medical history and diagnoses of [redacted] without behavioral disturbance and [redacted]. The [redacted] or behavioral status section showed the resident had a moderate [redacted]. Resident #33 was identified as not at risk for elopement. The resident needed assistance with the self-administration of medication. 2) Review of the hospital record revealed	{A 032}		

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{A 032}	Continued From page 30 Resident #26 arrived at the hospital on . . . . . Further review revealed "female with a history of advanced . . . . . presents by . . . from the ALF under . . . . . by police for aggressive behavior. Patient was refusing medications at the facility and . . . . . into the road according to . . . . report. Patient cannot remember what happened today or why she is here." During an interview on . . . . . at 9:30 AM the Director of Resident Care stated "On . . . . . , I don't know what happened. I wasn't involved in this." Review of Resident #26's record revealed an elopement assessment form completed on . . . . . . A review of Resident #26's health assessment completed on . . . . . revealed a medical history and diagnoses of . . . . . , ... , ... , history of . . . . . , and . . . . . . Resident #26 had physical limitations of using a walker to ambulate and a . . . . . status of . . . . . . The resident had precautions and was identified as an elopement risk. The resident was independent with ambulation, eating, and transferring and needed assistance with bathing, ... , grooming, toileting, and self-administration of medication. During an interview on . . . . . at 10:40 AM corporate staff, Staff AE, stated that "they said [Resident #26] went outside and the Staff F ran after her 20 seconds later, the staff followed her, the resident was letting go of her walker and 4 staff were around her and the resident was trying to hit the staff. I came around her and tried to calm her down, the resident scratched me and	{A 032}		

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{A 032}	Continued From page 31 started hitting me." Review of Resident #26's record revealed progress notes completed on that stated "At 1:15 PM, Resident was observed attempting to walk out of building, unaccompanied." During an interview on at 11:13 AM when asked what precautions were implemented after the elopement, the Director of Resident Care stated that "Extra insight was implemented. We check with the front desk to see if they saw the resident or kept an on her, that was in place until they would get a sitter or aide. There is no documentation of this." A review of an incident report revealed "On at 1 pm the receptionist notified that the resident was outside of the building. Caregivers came out at approximately 1:05 pm to help with resident outside of the building. At 1:10 pm caregivers brought resident into the building." A review of the facility's 24-hour communication report revealed on during the 6 AM-2:30 PM shift documented that the resident tried to run away and was found laying on her on the floor and the staff brought her . A review of the facility's internal incident report revealed "On receptionist and staff notified staff that resident was outside and didn't want to come in. Shortly, staff tried to encourage resident to come in she refused and slipped and hit on sidewalk." Further review of the facility's internal incident report revealed Staff AH, front desk receptionist, documented "Around 1 pm I saw her [Resident	{A 032}		

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{A 032}	Continued From page 32	{A 032}		

#26] walk around the 1st floor like she usually does. At about 1:3 PM, ('s PDA) came into the building from buying lunch and alerted me that she saw [Resident #26] walking around by [local restaurant], I walked and exited through the side door to go get her but didn't see her. When I came to the front desk, one of the staff members was walking with [Resident 26] to the building. Every attempt I made to persuade to make her come into the building she refused. The resident then began walking away from the building towards the Aloft."

During an interview on at 9:30 AM the Director of Resident Care stated "On I went to talk to her [Resident #26] and try and do an assessment, she told me get the [h--L] away and there's nothing I can do for her, I was only able to see her and I saw a small scrape, she wouldn't allow us to her assess her. On the resident finally allowed them to do ."

During an interview on at 9:53 AM Corporate Staff, Staff AE, stated "On the staff told me that the resident left the community. They followed her out and out there she . She was outside by herself at 1 pm. I called the daughter and said she had a scrape and needed to go to the hospital, the daughter said absolutely not. [Staff B] tried to clean her and the resident refused and the daughter refused to send her out to the hospital."

Review of Resident #26's record revealed progress notes completed on that stated "Once again, resident daughter was contacted regarding sending to the hospital and she refused. Staff states resident had on and area. Staff asked daughter if we are

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{A 032}	Continued From page 33 able to do an , and she stated it was not necessary." Review of the facility's elopement policies and procedures documented "The policy for the facility is that a resident will sign out when leaving the facility and sign in upon return to the facility in the 'Sign Out/Sign In' log (Temporary Absence Log). The log will include the residents name, date, and reason for temporary absence nor communicate with staff regarding his/her temporary absence, it is therefore understood by the facility that the resident left the facility without following the policy and procedures. Although the resident may travel independently in the community, the staff are responsible for knowing the general whereabouts of all residents." Uncorrected Class II	{A 032}		
{A 058} SS=E	429.42( ) FS; 58A-5.033(3)(a) FAC Pharmacy & Dietary; Uncorrected Deficiencies 429.42 Pharmacy and dietary services.- (1) Any assisted living facility in which the agency has documented a class I or class II deficiency or uncorrected class III deficiencies regarding medicinal drugs or over-the-counter preparations, including their storage, use, delivery, or administration, or dietary services, or both, during a biennial survey or a monitoring visit or an investigation in response to a complaint, shall, in addition to or as an alternative to any penalties imposed under s. 429.19, be required to employ the consultant services of a licensed pharmacist, a licensed registered nurse, or a registered or licensed dietitian, as applicable. The consultant	{A 058}		

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{A 058}	Continued From page 34 shall, at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required. (2) A corrective action plan for deficiencies related to assistance with the self-administration of medication or the administration of medication must be developed and implemented by the facility within 48 hours after notification of such deficiency, or sooner if the deficiency is determined by the agency to be life-threatening. 58A-5.033(3) (3) EMPLOYMENT OF A CONSULTANT. (a) Medication Deficiencies. 1. If a class I, class II, or uncorrected class III deficiency directly relating to facility medication practices as established in Rule 58A-5.0185, F.A.C., is documented by the agency pursuant to an inspection of the facility, the agency must notify the facility in writing that the facility must employ or contract the services of a pharmacist licensed pursuant to Section 465.0125, F.S., or registered nurse as determined by the agency. 2. After developing and implementing a corrective action plan in compliance with Section 429.42(2), F.S., the initial on-site consultant visit must take place within 7 working days of the notice of the class I or II deficiency and within 14 working days of the notice of an uncorrected class III deficiency. The facility must have available for review by the agency a copy of the license of the consultant pharmacist or registered nurse and the consultant's signed and dated review of the corrective action plan no later than 10 working days subsequent to the initial on-site consultant visit. 3. The facility must provide the agency with, at a minimum, quarterly on-site corrective action plan	{A 058}		

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{A 058}	Continued From page 35 updates until the agency determines after written notification by the consultant and facility administrator that deficiencies are corrected and staff has been trained to ensure that proper medication standards are followed and that such consultant services are no longer required. The agency must provide the facility with written notification of such determination. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have a copy of the license of the consultant pharmacist and the consultant's corrective action plan. The facility also failed to be under contract with a consultant licensed dietician who will, at a minimum, provide onsite quarterly consultations until an inspection by the Agency's personnel determines that such consultation services are no longer required. Finding include: A review of contract with a pharmacist" dated . . . . . , it showed that the company would provide monthly quality assurance audits of medication management by a license consultant pharmacist. A review of the facility records showed that the facility did not have a copy of the license of the consultant pharmacist. The facility also did not have the consultant's signed and dated review of the corrective action plan. In an interview on at 10:02 AM, Staff AE, "we have a medication consultant". Observation on at 7:00 AM, found no current menu dated for the week of ,	{A 058}		

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{A 058}	Continued From page 36 2022, through [redacted], conspicuously or easily available in the dining room. where residents could see it A further observation found no menu posted throughout the facility. Interviewed on at 7:54 AM, the Food Service Director stated that they do not have a bulletin board to post the menu, but he has it (menu) in a book. Interviewed on [redacted] at 11:57 AM, the Dining Room Manager stated, "We had a menu posted, but we were asked to remove it." Uncorrected Class III	{A 058}		
{A 077} SS=I	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an	{A 077}		

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{A 077}	Continued From page 37 administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least [illegible]; 2. If employed on or after [illegible], have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to [illegible], are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect	{A 077}		

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{A 077}	Continued From page 38 on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , , , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as	{A 077}		

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{A 077}	Continued From page 39 a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not . . . . . , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, ... , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that it was under the supervision of a qualified Administrator for more than 120 consecutive days. The Administrator, who was certified prior to the CORE training and certification examination failed to maintain continuing education requirements. Findings Included: A review of the facility's roster on the Background Screening Clearing House database showed that the Administrator was hired on . A review of the Administrator's records showed a hire date of . . . . . and a CORE competency test completed . Further review revealed a 6 Hour Continued Refresher Training completed on and a 12 hour Continued Refresher training completed on . . . . . There was no documentation of a 12 hour continued training completed every 2 years. The Administrator will be required to retake the CORE	{A 077}		

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{A 077}	Continued From page 40 and pass the test. During an interview on . . . . . at 12:48 PM the corporate staff, Staff AE, stated "He is in the process of hiring another administrator who will have this completed within 90 days." Uncorrected Class III	{A 077}		
{A 078} SS=I	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . . . . . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative . . . . . examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual . . . . . examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . . . . . . 2. If any staff member has, or is suspected of having, a communicable . . . . . , such individual	{A 078}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969444	A. BUILDING: _____ B. WING _____	R 08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA AT PARKSQUARE (THE)	2940 NE 207 STREET AVENTURA, FL 33180

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{A 078}	Continued From page 41 must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . . . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility . . . . . to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff . . . . . by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility	{A 078}		

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{A 078}	Continued From page 42 failed to ensure that two of 34 sampled staff were qualified to perform their assigned duties, consistent with their training (Direct Caregiver Staff L and Lead Med Tech Staff N). Staff N trained and certified on the subject, could not accurately describe how to perform (, ,). Staff L trained and certified on the subject, could not accurately explain a ( ). Findings included: 1. Review of Staff N showed that she completed the and First Aid training on that is valid until . On at 05:55 AM, Staff N stated, "We had training about 2 weeks ago. If a resident is unresponsive, we check if they have a , call 911, and begin of 10 , and 6 breaths. We don't stop until the begins to rise and the resident is breathing, or 911 arrives." "For healthcare providers and those trained: conventional using , and -to- breathing at a ratio of 30:2 , -to-breaths. In adult victims of , it is recommended for rescuers to perform , at a rate of 100 to 120/min and to a depth of at least 2 inches (5 cm) for an average adult, while excessive , depths (greater than 2.4 inches [6 cm]). Use your upper body (not just your arms) as you push straight down on (compress) the at least 2 inches (approximately 5 centimeters) but not greater than 2.4 inches	{A 078}		

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{A 078}	Continued From page 43 (approximately 6 centimeters). Push hard at a rate of 100 to 120 , a minute. If you haven't been trained in , continue , until there are signs of movement or until emergency medical personnel take over. If you have been trained in , go on to opening the airway and rescue breathing." 2. Review of Staff L personnel file showed that she completed the training on . On at 09:28 AM, Staff N stated, " .? Is it if you check the person , , then you give if the person doesn't have , . I don't know. I don't remember what it is. I took the class so long ago. Yes, [Staff AE] gave the class like 2 weeks ago. Yes, I took the class couple weeks ago, but I just don't remember what it is." When asked how do you know or identify which residents have a order? Staff L stated, "I don't know who has a . I don't remember. I remember the part." Class III	{A 078}		
{A 079} SS=I	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168	{A 079}		

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{A 079}	Continued From page 44	{A 079}		

212
16-25 253
26-35 294
36-45 335
46-55 375
56-65 416
66-75 457
76-85 498
86-95 539

For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week.
2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours.
3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility.
4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night.
5. A staff member who has completed courses in First Aid and [illegible]
( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times.
a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement.

Agency for Health Care Administration

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{A 079}	Continued From page 45 b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident	{A 079}		

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{A 079}	Continued From page 46 care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that	{A 079}		

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{A 079}	Continued From page 47 resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure adequate qualified staff were available for supervision and care for residents scheduled and unscheduled needs. A total of 74 calls were made from the residents' emergency call system pendants and went unanswered for more than 30 minutes within a period of seven days. Findings: Observation on at 5:04 AM, Staff N (Med-Tech/CAN/Shift Leader) Staff K, Staff X, Staff AK, and Staff AJ working and listed on the posted overnight schedule (from 10:00 PM-6:30 AM). A review of the call light logs on (14 calls went unanswered), (19 calls went unanswered), (9 calls went unanswered), (14 calls went unanswered), (5 calls went	{A 079}		

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{A 079}	Continued From page 48 unanswered), and [redacted] (13 calls went unanswered). The call log revealed 74 calls going unanswered for more than 30 minutes and up to four hours. Residents are issued call pendants for assistance by staff. Observation on [redacted] at 8:45 AM, showed six phones on a charger (phones #s: 1, 7, 9, 13, 12, & 19) in the Nursing Station. A further observation showed two phones out of service. Review of the facility's "Daily Phone Log Form" showed five phones were signed out by the morning shift staff, but on the scheduled showed nine employees working. A daily phone log form with sing-out dates of [redacted], and [redacted], showed that not all employees on the three shifts are signing out the call phones required to respond to calls from residents who needed assistance. Interviewed on [redacted] at 5:04 AM, Staff N (Med-Tech/Shift Leader) stated, "Resident #79 in [redacted] and went to the hospital yesterday. She had a bump on her [redacted]. She claimed that she called (Pendant), but the call did not appear in the computer. She called after she [redacted]. Front desk called us. They gave us a phone (pointed to the lunch area), but they're (phone) not working. No, she called front desk on the regular phone, and front desk called us." On [redacted] at 12:06 PM, Resident #61 stated that she was sick about two weeks ago on the weekend, which was a Sunday. She stated that she suffered from [redacted] and prone to it. Resident #61 stated that she pressed her emergency call pendant call at 8:20 AM and there was no response from the staff. Resident #61 then stated that she decided to call downstairs to	{A 079}		

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{A 079}	Continued From page 49	{A 079}		

the front desk and couldn't get anyone. Resident # 61 stated, "I called my family members at 9:30 AM to get the facility staff to come to her room because I was feeling sick. My family was calling the facility on every half hour. It was not only until 11:00 AM when a facility staff came to my room. Resident #61 stated further, "There are no nurses on the weekends. When the staff came to my room, she did not take my pressure. She swabbed me for a Covid-19 test. The med-tech put a swab in my . . . . . I don't have a private duty aid (PDA). After calling my children that was when I got a response." Regarding calling her family, Resident #61 stated that an administrative staff asked if her condition was so serious, why she did not call 911.

On at 5:26 AM, Resident 104's Private Duty Aid (PDA) stated, "he is like my family, I come every day 24/hours a day, I do everything for him because they do not do it. I used to call them with the call light, but they took too long to come. I change him, take the temperature, and give his medication. I think they do not have enough staff to take care of the residents."

On . . . . . at 8:45 AM, the daughter of Residents #72 and Resident #73 stated that now her parents have a private aid from 8:00 AM to 12:00 PM that comes to bath them, assist with their medication, and get them ready for their breakfast. The daughter stated further, "the reason why my parents have a private aid is because here they do not provide good services to my parents. I am thinking of hiring a full-time private aid for them because now they are getting older and will need more help. On during the morning, my father in the morning,

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{A 079}	Continued From page 50 and the private aid use the call light and the staff from this place took a very long time for them to come and take care of him." On . . . . . at 8:57 AM, the PDA for Resident #78 stated, "I come to assist her with everything every day from 8:00 AM to 6:00 PM, I clean her, bath her help her with the food and keep her company because the people who work here, they are too busy to do all that. This is a very nice place, but the problem is that they do not have enough staff to take care of all the residents." On . . . . . at 11:45 AM, the PDA for Resident #76 stated, "I come to work every day from 9:00 AM to 4:00 PM. I come and help him with all his activities of daily living (ADLs) because in this place the staff does not come to see him often enough. During the day they may come ones and that's it. Another PDA comes from 4:00 PM to 10:00 PM, the only time that he is alone is at night, when he is asleep." Interviewed on . . . . . at 10:15 AM, the Executive Director (Staff AC) stated that all the phones work. The Executive Director stated that the phones worked on Wi-fi and that he will install a system on the phones where the employees will be unable to disconnect the wi-fi on the phone. When asked why he was installing that system, the Executive Director stated, "So employees can't disconnect it. The Executive Director stated further, "They work (phones) and are brand new. As far as staffing, we have nine staff members in the mornings, nine staff members in evening and five staff members overnight (9, 9, & 5). We lost two staff members over the weekend. But we have been doing good with 9, 9, and 5 employees."	{A 079}		

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{A 079}	Continued From page 51 Interviewed on at 10:30 AM, Staff Y (Med-Tech) stated that to clear the call phones after the pendant is pushed, the staff must go to room and used a special key to clear the call. Staff Y stated further that there were 12 phones total and that they were six phones being used by staff and her assigned call phone #3 was not working. A review of the Emergency Call System policy given to the residents stated the following: "All residents will be issued an emergency call system pendant for use in case of emergency or non-emergency needs. This call system will notify a care giver who will then dispatched to your residence. Staff is on-site 24 hours per day, 7 days a week to respond to resident needs. Residents will be billed for lost emergency call systems medallions. The replacement pendant is $200.00." Uncorrected Class III	{A 079}		
{A 093} SS=I	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are	{A 093}		

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{A 093}	Continued From page 52 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 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	{A 093}		

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{A 093}	Continued From page 53	{A 093}		

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 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

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{A 093}	Continued From page 54 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 upon observation and interview, the facility failed to post a current menu reflective of the days of the week for 103 residents. The facility failed to plan a menu a week in advance. Findings: Observation on . . . . . at 7:00 AM, found no current menu dated for the week of , , through . . . . . , conspicuously or easily available in the dining room. A further observation found no menu posted throughout the facility. Interviewed on at 7:54 AM, the Food Service Director stated that they do not have a bulletin board to post the menu, but he has it (menu) in a book. Interviewed on . . . . . at 11:57 AM, the Dining Room Manager stated, "We had a menu posted, but we were asked to remove it." Uncorrected Class III	{A 093}		

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{A 162} SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C. (f) A ⌄ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their ⌄ recorded semi-annually. (g) For facilities that will have unlicensed staff	{A 162}		

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{A 162}	Continued From page 56	{A 162}		

assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract.
(h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C.
(i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C.
(j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S.
(k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S.
(l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families.
(m) Documentation of the of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney,

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{A 162}	Continued From page 57 where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively.	{A 162}		

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{A 162}	Continued From page 58 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have a completed health assessment for 16 out of 118 sampled residents (Residents # 21, 43, 46, 49, 70, 79, 80, 85, 87, 91, 92, 100, 107, 110, 113). Findings included: Review of Resident #21's health assessment showed the special precautions and elopement risk sections were left blank. Review of Resident #43's health assessment completed showed that the nursing/treatment/ , , service requirements section was left blank. Review of Resident #46's health assessment completed showed the first page was left blank. Review of Resident #49's health assessment showed the date of the examination was left blank. Review of Resident #70's health assessment showed pages 1, 2 and 3 were left blank. Review of Resident #79's health assessment showed the type of assistance needed with medications section was left blank. Review of Resident #80's health assessment showed the special precautions section and date of the examination were left blank. Review of Resident #85's health assessment	{A 162}		

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{A 162}	Continued From page 59 showed nursing/treatment/ , , service requirements and the special precautions section were left blank. Review of Resident #87's health assessment showed the special precautions section was left blank. Review of Resident #91's health assessment completed showed the special precautions section was left blank. Review of Resident #92's health assessment completed showed the type of assistance needed with medications was left unchecked and the nursing/treatment/ , , service requirements and special precautions sections were left blank. Also, the section on the first page that should be completed by the facility was incomplete. Review of Resident #100's health assessment showed the physical or sensory limitations, the , or behavioral status, the nursing/treatment/ , , service requirements, the special precautions section were left blank. Review of Resident #107's health assessment showed the special precautions section and the type of assistance needed with medications were left blank. Review of Resident #110's health assessment showed the medication list section, physician credentials, and date of the examination were left blank. Review of Resident #113's health assessment completed showed the special precautions section was left blank.	{A 162}		

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{A 162}	Continued From page 60 Review of Resident #81's Health assessment completed unknown, Health assessment not signed neither dated. On at 8:20 Staff AF stated, "all these files are being worked on, but they are so many that we need time to do it." Uncorrected Class III	{A 162}		
{A 165} SS=E	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her	{A 165}		

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{A 165}	Continued From page 61 consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The	{A 165}		

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{A 165}	Continued From page 62 agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to file an adverse incident report with the Agency for Healthcare Administration within 1 business day for one out of 119 sampled residents (Resident #8). Findings included: During an interview on at 7:33 AM, Staff U (medtech), stated "[Resident #8] needs one-on-one care. The family has been told, but they refuse to move the resident."	{A 165}		

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{A 165}	Continued From page 63 A review of Resident #8's progress note revealed "On per medtech (medication technician) staff the resident was seen with a fork in and held to another resident's and was also laughing out at staff being physically aggressive. 911 was called and transported the resident to the hospital." A review of the facility's internal incident report documented "On I was walking out of the kitchen serving breakfast. I saw the resident in front of another resident with a fork to her . . . I removed her away from the resident. Resident started hitting staff." A review of facility and Agency for Health Care Administration records revealed that the incident regarding Resident #8 was not reported. During an interview on at 1:46 PM the Executive Director stated "An internal incident report was completed but not an adverse. I was not here, we don't have an answer as to why it was not done." Uncorrected Class III	{A 165}		