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
	AL11965890	A. BUILDING: _____ B. WING _____	R 06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TROPICAL HEAVEN, INC	14201 SW 48 LANE MIAMI, FL 33175

(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
{CZ814}	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the [illegible] are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [illegible] submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; [illegible]; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain an updated employee roster within the background screening clearinghouse database for three out of six sampled staff (Staff B, Staff E and Staff F). Findings included:	{CZ814}		

AHCA Form 3020-0001

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

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{CZ814}	Continued From page 1 On at 5:45 AM, observation showed Staff E was the only staff on duty. On at 5:47 AM, Staff E confirmed that she was the only staff working. Review of the background screening clearinghouse database showed that Staff B, Staff E and Staff F were not listed on the roster. Further review showed Staff B was employed at the facility from until . Review of the facility's staff schedule dated showed that Staff B was still employed working 21 days that month with the latest day on . Staffing schedule also showed Staff F was employed at the facility working 20 days that month with the latest day on . On at 10:00 AM, the Administrator stated that Staff E was her aunt and did not work in the facility. Unclassified Uncorrected	{CZ814}		
{CZ815}	408.809(1)( ); 435.02(2); 435.06 FS Background Screening; Prohibited Offenses 408.809 Background screening; prohibited offenses.- (1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are considered employees for the purposes of conducting screening under chapter 435: (a) The licensee, if an individual.	{CZ815}		

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{CZ815}	Continued From page 2 (b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider. (c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider. (d) Any person who is a controlling interest. (e) Any person, as required by authorizing statutes, seeking employment with a licensee or provider who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, ... , with a licensee or provider whose responsibilities require him or her to provide personal care or personal services directly to clients, or . . . . . , with a licensee or provider to work 20 hours a week or more who will have access to client funds, personal property, or living areas. Evidence of contractor screening may be retained by the contractor's employer or the licensee. (3) All . . . . . must be provided in electronic format. Screening results shall be reviewed by the agency with respect to the offenses specified in s. 435.04 and this section, and the qualifying or disqualifying status of the person named in the request shall be maintained in a database. The qualifying or disqualifying status of the person named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee's behalf. (4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an . . . . awaiting final	{CZ815}		

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{CZ815}	Continued From page 3	{CZ815}		

disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction:
(a) Any authorizing statutes, if the offense was a felony.
(b) This chapter, if the offense was a felony.
(c) Section 409.920, relating to Medicaid provider fraud.
(d) Section 409.9201, relating to Medicaid fraud.
(e) Section 741.28, relating to domestic violence.
(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.
(g) Section 784.03, relating to battery, if the victim is a [redacted] adult as defined in s. 415.102 or a patient or resident of a facility licensed under chapter 395, chapter 400, or chapter 429.
(h) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.
(i) Section 817.234, relating to false and fraudulent insurance claims.
(j) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.
(k) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.
(l) Section 817.505, relating to patient brokering.
(m) Section 817.568, relating to criminal use of personal identification information.
(n) Section 817.60, relating to obtaining a credit card through fraudulent means.
(o) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.

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{CZ815}	Continued From page 4 (p) Section 831.01, relating to forgery. (q) Section 831.02, relating to uttering forged instruments. (r) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes. (s) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes. (t) Section 831.30, relating to fraud in obtaining medicinal drugs. (u) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony. (v) Section 895.03, relating to racketeering and collection of unlawful debts. (w) Section 896.101, relating to the Florida Money Laundering Act. If, upon rescreening, a person who is currently employed or with a licensee and was screened and qualified under s. 435.04 has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency no later than 30 days after receipt of the rescreening results by the person. (5) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The	{CZ815}		

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{CZ815}	Continued From page 5 Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening. (6)(a) As provided in chapter 435, the agency may grant an exemption from disqualification to a person who is subject to this section and who: 1. Does not have an active professional license or certification from the Department of Health; or 2. Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification. (b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may grant an exemption from disqualification to a person who is subject to this section and who has received a professional license or certification from the Department of Health or a regulatory board within that department and that person is providing a service within the scope of his or her licensed or certified practice. (7) The agency and the Department of Health may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, chapter 435, and authorizing statutes requiring background screening and to implement and adopt criteria relating to retaining [illegible] pursuant to s. 943.05(2). (8) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this section, terminates the person against whom the report was issued,	{CZ815}		

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{CZ815}	Continued From page 6 whether or not that person has filed for an exemption with the Department of Health or the agency. 435.06 Exclusion from employment.- (1) If an employer or agency has reasonable cause to believe that grounds exist for the denial or termination of employment of any employee as a result of background screening, it shall notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity. (2)(a) An employer may not hire, select, or otherwise allow an employee to have contact with any person that would place the employee in a role that requires background screening until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of employment. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select, or otherwise allow the employee to have contact with any person that would place the employee in a role that requires background screening unless the employee is granted an exemption for the disqualification by the agency as provided under s. 435.07. (b) If an employer becomes aware that an employee has been for a disqualifying offense, the employer must remove the employee from contact with any person that places the employee in a role that requires background screening until the is resolved in a way that the employer determines that the	{CZ815}		

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{CZ815}	Continued From page 7	{CZ815}		

employee is still eligible for employment under this chapter.
(c) The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of this chapter or place the employee in a position for which background screening is not required unless the employee is granted an exemption from disqualification pursuant to s. 435.07.
(d) An employer may hire an employee to a position that requires background screening before the employee completes the screening process for training and orientation purposes. However, the employee may not have direct contact with persons until the screening process is completed and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment.
(3) Any employee who refuses to cooperate in such screening or refuses to timely submit the information necessary to complete the screening, including , if required, must be disqualified for employment in such position or, if employed, must be dismissed.
(4) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages against, an employer that, upon notice of a conviction or for a disqualifying offense listed under this chapter, terminates the person against whom the report was issued or who was , regardless of whether or not that person has filed for an exemption pursuant to this chapter.

435.02 Definitions.-For the purposes of this chapter, the term:
(2) "Employee" means any person required by law to be screened pursuant to this chapter,

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{CZ815}	Continued From page 8 including, but not limited to, persons who are contractors, licensees, or volunteers. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to conduct a level II background screening for any person whose responsibilities may require him or her to provide personal care or services directly to clients or have access to client funds, personal property, or living areas for one out of six sampled staff (Staff E). Findings included: On at 5:45 AM, observation showed Staff E was the only staff on duty caring for 6 residents. Staff E was entering into residents' rooms. On at 5:47 AM, Staff E confirmed that she was the only staff working. On at 9:52 AM, when asked if she had an identification, Staff E stated that she left her identification at home and provided her full name and date of birth. Review of the background screening clearinghouse database found no results of a level II background screening conducted to Staff E with the information she provided. Uncorrected Unclassified	{CZ815}		

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{A 000}	Initial Comments A second revisit to a re-licensure survey, in conjunction with a complaint investigation (complaint #2022007958) was conducted at Tropical Heaven, Inc on . . . . . Deficiencies were identified at the time of the survey.	{A 000}		
{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 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	{A 025}		

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{A 025}	Continued From page 1 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 maintain a written record, updated as needed, of any significant changes or illnesses resulting in medical attention for three out of 19 sampled residents (Residents #3, #17, #18). Findings include: 1) During an interview on . . . . . at 7:04 AM, the Administrator stated, "[Resident #3] was discharged to hospital on . . . . . to [hospital]. He was very weak. He began not to swallow. He went to rehab, and because we were over capacity, we decided not to take him ."	{A 025}		

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{A 025}	Continued From page 2 A review of the admission/discharge log showed no discharge date or place where the resident was discharged. On at 7:14 AM, the Administrator stated, "I don't have any progress notes," when requested progress notes about the resident's transfer to the hospital. 2) In an interview with the Administrator on at 8:35 AM, she stated that Residents #17 and #18 were discharged from the facility. On at 8:45 AM, when asked for documentation of the resident's discharge from the facility, the Administrator stated, "Just put that I don't have it." Class III Uncorrected	{A 025}		
{A 026} SS=F	59A-36.007(2) FAC Resident Care - Social & Leisure Activities (2) SOCIAL AND LEISURE ACTIVITIES. Residents shall be encouraged to participate in social, recreational, educational and other activities within the facility and the community. (a) The facility must provide an ongoing activities program. The program must provide diversified individual and group activities in keeping with each resident's needs, abilities, and interests. (b) The facility must consult with the residents in selecting, planning, and scheduling activities. The facility must demonstrate residents' participation through one or more of the following methods: resident meetings, committees, a resident	{A 026}		

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{A 026}	Continued From page 3 council, a monitored suggestion box, group discussions, questionnaires, or any other form of communication appropriate to the size of the facility. (c) Scheduled activities must be available at least 6 days a week for a total of not less than 12 hours per week. Watching television is not an activity for the purpose of meeting the 12 hours per week of scheduled activities unless the television program is a special one-time event of special interest to residents of the facility. A facility whose residents choose to attend day programs conducted at adult day care centers, senior centers, mental health centers, or other day programs may count those attendance hours towards the required 12 hours per week of scheduled activities. An activities calendar must be posted in common areas where residents normally congregate. (d) If residents assist in planning a special activity such as an outing, seasonal festivity, or an excursion, up to 3 hours may be counted toward the required activity time. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to post a current monthly activities calendar for the month of . Findings: Observations on at 7:15AM, a monthly activities calendar for the month of was posted on the bulletin area in the common area. Interviewed on at 7:15AM, the Owner stated, "I came to work today to do it (activities calendar)"	{A 026}		

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{A 026}	Continued From page 4 Class III	{A 026}		
{A 030} SS=E	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be	{A 030}		

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{A 030}	Continued From page 5 included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident . . . . . , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. . . . . control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.-	{A 030}		

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{A 030}	Continued From page 6 (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility.	{A 030}		

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{A 030}	Continued From page 7	{A 030}		

(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community.
(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual

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{A 030}	Continued From page 8	{A 030}		

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

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{A 030}	Continued From page 9 . . . . . Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated . . . . . or . . . . . under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to honor resident rights and ensure residents were treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy for three out of nineteen sampled residents (Residents #2, Resident #7 and Resident #9). Findings included: On at 5:47 AM, observation showed in # were Resident #2, Resident #7 and Resident #9, all under hospice care, lying in bed	{A 030}		

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{A 030}	Continued From page 10 with full bed rails in upright position. The personal living space for each resident was less than 30 . . . . On . . . . . at 6:52 AM, observation showed a home health aide (HHA) from hospice assisted Resident #7 with bathing and . . . . in the presence of Resident #2 and Resident #9. Resident #7 was totally nude and then the HHA placed a sheet over the resident's private area. On at 7:31 AM, when asked if this was the way he always bathed the residents without privacy, the HHA stated, "Yes, I always do that. It's 3 people in a room what can I do." Class III Uncorrected	{A 030}		
{A 032} SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or	{A 032}		

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{A 032}	Continued From page 11 415.1051, 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 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	{A 032}		

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{A 032}	Continued From page 12 facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to follow its policies and procedures regarding residents assessed for elopement or with any history of elopement for one out of nineteen sampled residents (Resident #10). Findings included: On at 9:55 AM, during an interview Resident #10 stated that he did not know where he lived and did not know the address of the facility. When asked if he had an identification with him Resident #10 stated that he did not have one. Review of Resident #10's health assessment showed the resident was not identified as risk for elopement. However, Resident #10 had diagnosis of and his and behavioral status revealed the resident was disoriented in time and forgetfulness. Review of the facility's elopement policies and procedures revealed that: "At [ALF], "Elopement" refers to an unauthorized absence of a resident from the facility. The risk of and elopement increases when residents are mobile and ; especially if they suffer from or ." Class III Uncorrected	{A 032}		

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{A 056} SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic	{A 056}		

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{A 056}	Continued From page 14 copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date.	{A 056}		

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{A 056}	Continued From page 15 (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on Observation and Interview, the facility failed to ensure that the prescription for Resident #19 who received assistance with self-administration of medication was filled in a timely manner. Findings: Based on observations on at 7:45AM, two packs prescribed for Resident #19 were found empty. Interviewed on at 7:21AM, Resident #19 stated that she must go to the pharmacy to pick up her medication. Resident #19 stated further that she received medication from the staff and saw staff giving medication to all the residents. Interviewed on at 7:30AM, the Owner stated that Resident #19 went without medication for the past two days and she must go the pharmacy to pick-up her medication. Class III	{A 056}		
A 077 SS=I	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators	A 077		

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A 077	Continued From page 16 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. 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];	A 077		

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A 077	Continued From page 17 2. If employed on or after . . . . . , . . . , 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 , , , are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, 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	A 077		

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	AL11965890	A. BUILDING: _____ B. WING _____	R 06/02/2022

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A 077	Continued From page 18 and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator 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 observation, record review, and interview, the facility failed to have an administrator capable of handling the operation and maintenance of the facility, including the	A 077		

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A 077	Continued From page 19 management of all staff and residents. The Administrator failed to maintain business records that identify, summarize, and classify funds received and expenses disbursed. The Administrator failed to maintain personnel and resident records required to be readily available on facility premises. The Administrator failed to ensure staff was properly trained in assisting with the self-administration of medication. The Administrator failed to know how to operate the generator onsite in the event of losing primary electrical power. Findings include: 1) A review of the facility's roster on the Background Screening Clearinghouse database showed that the Administrator was hired on [redacted]. During an interview on [redacted] at 6:24 AM, the Administrator stated Resident #8, Resident #10, and Resident #19 were a part of a hospital program that finds placement for unfunded individuals. A review of the facility's records showed no evidence of a record for Residents #9 and #19. In an interview on [redacted] at 8:20 AM, when asked if she had the records for Residents #9 and #19, the Administrator stated, "Just put that I don't have it." A review of the facility's records showed no documentation of financial records detailing the amount of income received for each resident. During an interview on [redacted] at 6:35 AM, when asked for the facility's financial records,	A 077		

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A 077	Continued From page 20 including the facility's bank statements, the Administrator stated, "It's on my computer. I didn't know I had to have it on paper. Just put, I don't have it. I don't have a bank account for the facility. I didn't know I was supposed to have one." On at 6:36 AM, when asked whether she provided the resident's receipts or had records of the resident's payment, the Administrator stated, "I don't have records of residents paying rent. I don't give them receipts. I didn't know I had to keep records." 2) A review of the facility's admission/discharge log showed Residents #1 and #5 still listed as residing at the facility. Further review showed that Residents #11 and #13 were not listed. On at 6:36 AM, when asked why the facility had a stockpile of unlocked medication throughout their building, the Administrator stated, "The medication belongs to [hospital] program. They told me to keep the medication when the residents leave. Sometimes they ask for it . . . , and I must drop it off to them." 2) Observation on at 6:27 AM showed a portable generator (Predator 9000 running watts Generator) located in the facility's backyard. On . . . . . at 6:29 AM, when asked how much fuel was needed for the generator to run for 48 hours, the Administrator stated, "Do you think I can remember how many gallons is needed at this time?" Observation on . . . . . at 6:30 AM showed the Administrator attempting to turn on the generator. At 6:33 AM, the Administrator poured gasoline into the generator's tank and continued	A 077		

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A 077	Continued From page 21 her attempt to turn on the generator without success. During an interview on at 6:42 AM, the Administrator stated, "I didn't know how to start it, but it's new." 3) Observation on at 5:55 AM during the facility tour showed an unlocked medication bottle labeled with Resident #2's name and three unlocked bottles of medication labeled with Resident #10' s name stored inside a clear plastic bag on the floor of the closet in # . Observation on at 6 AM showed unlocked medication packs labeled with Resident #7 and #9's names stored inside the facility's dryer. During an interview on at 6:41 AM, when asked why the medication was being stored inside of the dryer, the Administrator stated, "I don't know why the medication was in the dryer." Observation on at 6:13 AM showed an unlocked comfort kit from hospice belonging to Resident #8 inside the refrigerator. Also, inside the refrigerator observed a locked metal box containing two vials of , one prescribed to Resident #5 and an unknown person. In an interview on at 7:04 AM, when asked the reason why Resident #8's comfort kit was stored unlocked, the Administrator stated, "I didn't have space." Observation on at 5:57 AM showed five unlocked bottles of medication prescribed to Resident #11 inside a Ziplock bag in a kitchen drawer. Further, observation showed a bottle of	A 077		

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A 077	Continued From page 22 . . . . . prescribed to Resident #1 in a bottom kitchen cabinet next to the refrigerator. Observation on at 6:45 AM showed unlocked medication stored in a plastic bag inside an armoire in # . Medication included three vials of . . prescribed to Resident #5 and two other unknown persons prescribed in 2018, a bottle of . . . . , . . labeled with Resident #2's name, and a . Flex inhaler labeled with Resident #13's name. In an interview on . . . . . at 7:06 AM, the Administrator stated, "Because [the facility] was found being overcapacity, only people living here is Resident #2, #7, #8, #9, #10, and #19." A review of the facility's admission/discharge log showed that residents #1 and #5 were listed as current. Further review showed no notation of Residents #11 and #13 on the log. 4) A review of the facility's medication observation record (MOR) showed no documentation of MORs for Residents #10 and #19. Further review showed morning medications for Resident #2 were not signed or initialed as given on . Reconciliation of medication for Resident #2 showed that the medications given were Nitrofur 50 mg (used to treat or prevent certain , ...), ... 25 mg (used with or without other medications to treat high , ...), ... , . . 650 mg (used to treat mild to moderate , . .), , . 20 mg (used to treat certain . . . . . and . . . . , . . problems), 20 mg (used to treat spasms caused by certain conditions), . .25 mg (used to treat , and	A 077		

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A 077	Continued From page 23), 100 mg (used with other medications to prevent and control), 1 gm (used to prevent or control returning) and SOD 100 mg (used to treat occasional). A review of Resident #2's health assessment dated showed medical diagnoses and a history of specified with loss, , mental , gait , frequent , and pressure to Area . Further review of the health assessment revealed that the resident required total care with ambulation, bathing, , eating, self-care, toileting, transferring, and assistance with self-administration of medication. On at 6 AM, when asked how she provides medication to the hospice residents, Staff E stated, "I assist with medication, but I don't put it in their . I put it in the cup." Observation on at 6:01 AM showed Staff E opening a drawer near the kitchen sink with a pre-poured medication cup with Resident #2's name stacked on top of other medication cups labeled with Resident #7, #9, and #10 names. On at 6:15 AM, Staff E retracted her statement and stated, "Hospice nurse gives them the medication. I don't know what company they work for." During an interview on at 6:09 AM, when asked the reason she poured the	A 077		

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A 077	Continued From page 24 medication, Staff E stated, "I don't know. I don't have an explanation. I don't do it every day." Observation on at 7:28 AM, showed a licensed practical nurse (LPN) from hospice arrive at the facility. On at 7:29 AM, the LPN introduced himself and stated, "I come to [Residents #2, #7, and #9] medication. I usually come at 7 or 8 AM." On at 7:32 AM, observed the hospice LPN search and find Resident #2's packs and exclaim, "They take the medication?". When asked if this had occurred before, the LPN stated, "No, I have to come here anyway." The LPN then inquired where Resident #2's medication was to the Administrator and Staff E, who then passed him the pre-poured medication cup labeled with Resident #2's name. During an interview on with Resident #19 at 7:50 AM, she stated, "Everyone gets their medication at the same time. They look at the packs and pop the tablets into the little cups with our names on them. They sign it and give it to us at the same time, even the people on hospice." On at 10 AM, the Administrator stated, "She doesn't have one," when asked to provide Staff E's personnel record. "She is my aunt. She is not working." Class II	A 077		
(A 079) SS=D	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum	(A 079)		

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{A 079}	Continued From page 25	{A 079}		

staff hours per week:

Number of Residents, Day Care Participants, and Respite Care Residents	Staff Hours/Week
0-5	168
	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 , , ( ) and holds a currently valid card

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{A 079}	Continued From page 26	{A 079}		

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

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{A 079}	Continued From page 27	{A 079}		

apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C.
(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

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{A 079}	Continued From page 28 by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing 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 record review, the facility failed to maintain minimum staff on duty to meet the scheduled and unscheduled needs of six residents, including four residents receiving hospice services. Also, the facility failed to maintain a written work schedule. Findings include: Observation during the facility tour on . . . . . at approximately 5:45 AM showed six residents residing at the facility. Further observation revealed Staff E (caregiver) working alone at the facility. On . . . . . at 5:47 AM, when asked if other staff were working with her, Staff E stated, "No, I	{A 079}		

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{A 079}	Continued From page 29 am the only one working here." During an interview on at 6:15 AM, the Administrator stated, "I just left when you guys came." A review of the facility's records showed a staffing schedule dated . On at 6:39 AM, when asked if she had a current staffing schedule, the Administrator stated, "I was coming to do that today." Uncorrected Class III	{A 079}		
{A 152} SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident,	{A 152}		

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{A 152}	Continued From page 30 2. A closet or wardrobe space for hanging clothes, 3. A dresser, . . . or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe living environment to residents and to ensure that all existing architectural, mechanical, electrical, and structural systems, and appurtenances are maintained in good working order. Findings included: On during the facility tour observations showed: 5:53 AM Rodent droppings on the floor near the employee's bed in the portion of the facility. 5:54 AM There were cracked tiles in the bathroom shower in the portion of the facility. 5:55 AM A chicken was tied to a laundry hamper in the backyard. 6:19 AM A tarp was on the facility's roof outside.	{A 152}		

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	AL11965890	A. BUILDING: _____ B. WING _____	R 06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TROPICAL HEAVEN, INC	14201 SW 48 LANE MIAMI, FL 33175

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 152}	Continued From page 31 6:22 AM There were brown spots on the roof of # which appeared to be water. 6:31 AM There were mattresses stacked on their sides on the side of the house near the generator. 6:48 AM There were debris in the backyard which included recliner chair, wheelchairs and hospital beds On . . . . . at 6:23 AM, in an interview with the Administrator, she stated, "[The roof] has been leaking for a month and a half." On . . . . . at 6:35 AM, when asked for documentation of pest control, the Administrator stated, "I don't have it. I have to call the company to see if they can send it to me." Class III Uncorrected	{A 152}		
A 200 SS=H	59A-36.025 FAC Emergency Environmental Control 59A-36.025 Emergency Environmental Control for Assisted Living Facilities. (1) DETAILED EMERGENCY ENVIRONMENTAL CONTROL PLAN. Each assisted living facility shall prepare a detailed plan ("plan") to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency environmental control in the event of the loss of primary electrical power in that assisted living facility which includes the following information: (a) The acquisition of a sufficient alternate power source such as a generator(s), maintained at the assisted living facility, to ensure that current licensees of assisted living facilities will be equipped to ensure . . . . air temperatures will	A 200		

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A 200	Continued From page 32 be maintained at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. 1. The required temperature must be maintained in an area or areas, determined by the assisted living facility, of sufficient size to maintain residents safely at all times and that is appropriate for resident care needs and life safety requirements. For planning purposes, no less than twenty (20) net square per resident must be provided. The assisted living facility may use eighty percent (80%) of its licensed bed capacity as the number of residents to be used in the to determine the required square footage. This may include areas that are less than the entire assisted living facility if the assisted living facility's comprehensive emergency management plan includes allowing a resident to congregate when he or she desires in portions of the building where temperatures will be maintained and includes procedures for monitoring residents for signs of heat related injury as required by this rule. This rule does not prohibit a facility from acting as a receiving provider for evacuees when the conditions stated in section 408.821, F.S. and subsection 59A-36.019(5), F.A.C., are met. The plan shall include information regarding the area(s) within the assisted living facility where the required temperature will be maintained. 2. The alternate power source and fuel supply shall be located in an area(s) in accordance with local zoning and the Florida Building Code. 3. Each assisted living facility is unique in size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and staffing characteristics. Accordingly, this rule does not limit the types of systems or	A 200		

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A 200	Continued From page 33 equipment that may be used to achieve temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. The plan shall include information regarding the systems and equipment that will be used by the assisted living facility and the fuel required to operate the systems and equipment. a. An assisted living facility in an evacuation zone pursuant to chapter 252, F. S. must maintain an alternative power source and fuel as required by this subsection at all times when the assisted living facility is occupied but is permitted to utilize a mobile generator(s) to enable portability if evacuation is necessary. b. Assisted living facilities located on a single campus with other facilities under common ownership, may share fuel, alternative power resources, and resident space available on the campus if such resources are sufficient to support the requirements of each facility's residents, as specified in this rule. Details regarding how resources will be shared and any necessary movement of residents must be clearly described in the emergency power plan. c. A multistory facility, whose comprehensive emergency management plan is to move residents to a higher floor during a flood or surge event, must place its alternative power source and all necessary additional equipment so it can safely operate in a location protected from flooding or storm surge damage. (b) The acquisition of sufficient fuel, and safe maintenance of that fuel at the facility, to ensure that in the event of the loss of primary electrical power there is sufficient fuel available for the alternate power source to maintain temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours after the	A 200		

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A 200	Continued From page 34 loss of primary electrical power during a declared state of emergency. The plan must include information regarding fuel source and fuel storage. 1. Facilities must store minimum amounts of fuel onsite as follows: a. A facility with a licensed capacity of 16 beds or less must store 48 hours of fuel onsite. b. A facility with a licensed capacity of 17 or more beds must store 72 hours of fuel onsite. 2. An assisted living facility located in an area in a declared state of emergency area pursuant to section 252.36, F.S. that may impact primary power delivery must secure ninety-six (96) hours of fuel. The assisted living facility may utilize portable fuel storage containers for the remaining fuel necessary for ninety-six (96) hours during the period of a declared state of emergency. 3. Piped natural gas is an allowable fuel source and meets the onsite fuel supply requirements under this rule. 4. If local ordinances or other regulations limit the amount of onsite fuel storage for the assisted living facility's location, then the assisted living facility must develop a plan that includes maximum onsite fuel storage allowable by the ordinance or regulation and a reliable method to obtain the maximum additional fuel at least 24 hours prior to depletion of onsite fuel. (c) The acquisition of services necessary to maintain, and test the equipment and its functions to ensure the safe and sufficient operation of the alternate power source maintained at the assisted living facility. (d) The acquisition and maintenance of a . . . . monoxide alarm. (2) SUBMISSION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall submit its plan	A 200		

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A 200	Continued From page 35 to the local emergency management agency for review within 30 days of the effective date of this rule. Assisted living facility plans previously submitted and approved pursuant to emergency Rule 58AER17-1 will require resubmission only if changes are made to the plan. (b) Each new assisted living facility shall submit the plan required under this rule prior to obtaining a license. (c) Each existing assisted living facility that undergoes any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of its systems or equipment affecting the facility's compliance with this rule shall amend its plan and submit it to the local emergency management agency for review and approval. (3) APPROVED PLANS. (a) Each assisted living facility must maintain a copy of its approved plan in a manner that makes the plan readily available at the licensee's physical address for review by a legally authorized entity. If the plan is maintained in an electronic format, assisted living facility staff must be readily available to access and produce the plan. For purposes of this section, "readily available" means the ability to immediately produce the plan, either in electronic or paper format, upon request. (b) Within two (2) business days of the approval of the plan from the local emergency management agency, the assisted living facility shall submit in writing proof of the approval to the Agency for Health Care Administration. (c) The assisted living facility shall submit a consumer-friendly summary of the emergency power plan to the Agency. The Agency shall post the summary and notice of the approval and implementation of the assisted living facility	A 200		

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A 200	Continued From page 36 emergency power plans on its website within ten (10) business days of the plan's approval by the local emergency management agency and update within ten (10) business days of implementation. (4) IMPLEMENTATION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall, no later than . . . . . , have implemented the plan required under this rule. (b) The Agency shall allow an extension up to . . to providers in compliance with paragraph (c) below and who can show delays caused by necessary construction, delivery of ordered equipment, zoning or other regulatory approval processes. Assisted living facilities shall notify the Agency that they will utilize the extension and keep the Agency apprised of progress on a quarterly basis to ensure there are no unnecessary delays. If an assisted living facility can show in its quarterly progress reports that unavoidable delays caused by necessary construction, delivery of ordered equipment, zoning or other regulatory approval processes will occur beyond the initial extension date, the assisted living facility may request a waiver pursuant to section 120.542, F.S. (c) During the extension period, an assisted living facility must make arrangements pending full implementation of its plan that provides the residents with an area or areas to congregate that meets the safe indoor air temperature requirements of subsection (1) (a) for a minimum of ninety-six (96) hours. 1. An assisted living facility not located in an evacuation zone must either have an alternative power source onsite or have a contract in place for delivery of an alternative power source and fuel when requested. Within twenty-four (24)	A 200		

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A 200	Continued From page 37	A 200		

hours of the issuance of a state of emergency for an event that may impact primary power delivery for the area of the assisted living facility, it must have the alternative power source and no less than ninety-six (96) hours of fuel stored onsite.
2. An assisted living facility located in an evacuation zone pursuant to chapter 252, F.S. must either:
a. Fully and safely evacuate its residents prior to the arrival of the event; or
b. Have an alternative power source and no less than ninety-six (96) hours of fuel stored onsite, within twenty-four (24) hours of the issuance of a state of emergency for the area of the assisted living facility.
(d) Each new assisted living facility shall implement the plan required under this rule prior to obtaining a license.
(e) Existing assisted living facilities that undergo any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of the systems or equipment affecting the assisted living facility's compliance with this rule shall implement its amended plan concurrent with any such additions, modifications, alterations, refurbishment, renovations or reconstruction.
(f) The Agency for Health Care Administration may request cooperation from the State Fire Marshal to conduct inspections to ensure implementation of the plan in compliance with this rule.
(5) POLICIES AND PROCEDURES.
(a) Each assisted living facility shall develop and implement written policies and procedures to ensure that the assisted living facility can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power

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A 200	Continued From page 38 source. The procedures shall ensure that residents do not experience complications from fluctuations in air temperatures inside the facility. Procedures must address the care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury including: 1. The use of cooling devices and equipment; 2. The use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration; 3. Wellness checks by assisted living facility staff to monitor for signs of and heat injury; and 4. A provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy. (b) Each assisted living facility shall maintain the written policies and procedures in a manner that makes them readily available at the licensee's physical address for review by a legally authorized entity. If the policies and procedures are maintained in an electronic format, assisted living facility staff must be readily available to access the policies and procedures and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce the policies and procedures, either in electronic or paper format, upon request. (c) The written policies and procedures must be readily available for inspection by each resident; each resident's legal representative, designee, surrogate, guardian, attorney in fact, or case manager; each resident's estate; and such additional parties as authorized in writing or by law. (6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this	A 200		

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A 200	Continued From page 39 rule, the Agency for Health Care Administration may seek any remedy authorized by chapter 429, part I, or chapter 408, part II, F.S., including, but not limited to, license revocation, license suspension, and the imposition of administrative fines. (7) COMPREHENSIVE EMERGENCY MANAGEMENT PLAN. (a) Assisted living facilities whose comprehensive emergency management plan is to evacuate must comply with this rule. (b) Each facility whose plan has been approved shall submit the plan as an addendum with any future submissions for approval of its comprehensive emergency management plan. (8) NOTIFICATION. (a) Within five (5) business days, each assisted living facility must notify in writing, unless permission for electronic communication has been granted, each resident and the resident's legal representative: 1. Upon submission of the plan to the local emergency management agency that the plan has been submitted for review and approval; 2. Upon final implementation of the plan by the assisted living facility. (b) Each assisted living facility must maintain a copy of each notification set forth in paragraph (a) above in a manner that makes each notification readily available at the licensee's physical address for review by a legally authorized entity. If the notifications are maintained in an electronic format, facility staff must be readily available to access and produce the notifications. For purposes of this section, "readily available" means the ability to immediately produce the notifications, either in electronic or paper format, upon request. This Statute or Rule is not met as evidenced by:	A 200		

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A 200	Continued From page 40 Based on observation, record review, and interview, the facility failed to ensure that staff on duty knew how to operate a generator to ensure air temperatures would be maintained at or below 81 degrees Fahrenheit (F) in the event of the loss of primary electrical power. The facility failed to ensure sufficient fuel for the alternate power source to maintain temperatures at or below 81 degrees Fahrenheit. Findings include: 1) Observation on at 6:27 AM showed a portable generator (Predator 9000 running watts Generator) located in the facility's backyard. Observation on at 6:30 AM showed the Administrator attempting to turn on the generator. At 6:33 AM, the Administrator poured gasoline into the generator's tank and continued her attempt to turn on the generator without success. During an interview on at 6:42 AM, the Administrator stated, "I didn't know how to start it, but it's new." 2) A review of the manual showed the generator had an 8 gallons tank capacity for gasoline with 13 hours runtime on half load. On at 6:28 AM, observed five 5-gallon containers of gasoline (three containers were ¾ full, one container was ½ full, and one container was full) located in the backyard of the facility. The facility had enough gasoline for the generator to run for 25 hours. On at 6:29 AM, when asked how much fuel was needed for the generator to run for	A 200		

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A 200	Continued From page 41 48 hours, the Administrator stated, "Do you think I can remember how many gallons is needed at this time?" Class II	A 200		
{A 160} SS=E	59A-36.015(1) FAC Records - Facility The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a [illegible]; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to rule 59A-36.018, F.A.C. If the resident dies while in the care of the	{A 160}		

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{A 160}	Continued From page 42 facility, the log must indicate the date of . . . . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with . . . . 's . . . . or related . . . . . , a copy of all such facility advertisements as required by section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in rule 59A-36.007, F.A.C. (j) All food service records required in rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to section 429.41, F.S., and rule chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the	{A 160}		

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{A 160}	Continued From page 43 county health department pursuant to section 381.031, F.S., and chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain an up-to-date admission/discharge log. Findings include: 1) Observation during the facility tour on at approximately 5:50 AM Resident #9 lying in bed in . Observation on at 6:21 AM showed Resident #10 eating breakfast in the facility's dining room area. During an interview on at 6:47 AM, Resident #8 stated, "I have been living here since ." On at 7:21 AM, when asked how long she has been residing at the facility, Resident #19	{A 160}		

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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 160}	Continued From page 44 stated, "I have been staying here for the past month." A review of the facility's admission/discharge log showed Residents #8, #10, and #19 were not listed. 2) In an interview on at 7:06 AM, the Administrator stated, "Because of [the facility] was found being overcapacity, only people living here is Resident #2, #7, #8, #9, #10, and #19." A review of the facility's admission/discharge log showed Residents #5 and #6 were listed. Additionally, there was no documentation of the discharge date, the reason for discharge, or where the residents were discharged. On at 6:22 AM, when asked if the facility had an updated admission/discharge log, the Administrator stated, "No, it's not updated." Class III Uncorrected	{A 160}		
{A 162} SS=F	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 ,	{A 162}		

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	AL11965890	A. BUILDING: _____ B. WING _____	R 06/02/2022

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{A 162}	Continued From page 45 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 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	{A 162}		

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{A 162}	Continued From page 46 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 [illegible] recipient, a copy of the Department of Children and Families form Alternate Care Certification for [illegible] ([illegible]), CF-ES 1006, [illegible], 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 [illegible] of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, 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 [illegible], 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,	{A 162}		

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{A 162}	Continued From page 47 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. This Statute or Rule is not met as evidenced by: Based on Record Review and Interview, the facility failed to maintain Resident Records for six out six sampled residents at the facility. Findings: A record review on . . . . . found no demographic data for Residents #2, #7, #8, #9, #10, and #19. A record review of Residents #2 health	{A 162}		

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{A 162}	Continued From page 48	{A 162}		

assessment completed on [redacted] and needed to be updated as required. Resident #2's health assessment does not indicate he has a [redacted]. Resident #2 was diagnosed with [redacted] with [redacted] loss, [redacted], Mental [redacted], Gait [redacted] to [redacted]. Resident needed total acre in activities of daily living and assistance with self-administration.

A record review on [redacted] of Resident #7's health assessment completed [redacted] does not indicate that he is under hospice care. Resident #7 was diagnosed with [redacted], Gait Disturbance, [redacted], Hypoxemia and [redacted]. Activities of daily living showed resident needed supervision in ambulation but assistance in bathing, [redacted], self-care, and toileting.

A record review on [redacted] of Resident #8's health assessment completed [redacted] showed no indication that resident is under hospice care. Resident was diagnosed with [redacted]. Resident was independent in all activities of daily living.

A record review on [redacted] of Resident #9's file found no contract. A review of his health assessment completed [redacted] does not indicate that the resident is under hospice care. A further review found that the resident can administer his own medication. Interview on [redacted] at 7:29AM, the Hospice Nurse stated that he came to the facility to administer medication to residents #2, #7 and #9. Resident

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{A 162}	Continued From page 49 was diagnosed with and Acute Visemic [illegible] and Generalized [illegible]. A record review on [illegible] of Resident #10's file found an unsigned contract undated. A further review of the Resident #10's health assessment showed no completion date. The resident was diagnosed with [illegible], History of [illegible], Generalized [illegible], [illegible], History of Drug [illegible], [illegible] and [illegible]. Activities of daily living showed independent in ambulation, eating, toileting, and transferring but needed supervision in bathing, [illegible] and self-care. Resident #19 does not have a file including contract and a completed health assessment. Interviewed on [illegible] at 8:20AM, the Administrator stated, "Just put that down. I don't have it." Uncorrected Class III	{A 162}		
{A 165} SS=D	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.	{A 165}		

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{A 165}	Continued From page 50 (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 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	{A 165}		

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{A 165}	Continued From page 51 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 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:	{A 165}		

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{A 165}	Continued From page 52 Based on record reviews and interviews, the facility failed to provide within one business day after the occurrence of an adverse incident in a preliminary report. The facility failed to file within 15 days after the occurrence of an elopement, a full report to the Agency that included the results of the facility's investigation into the adverse incident. Findings: Record review of Adverse Incident Reports (AIRS) on . . . . . showed no full report to the Agency of an elopement that occurred on . . . . An initial report was placed on . Record review of AIRS on found no preliminary report filed nor a full report to the agency that included the results of the facility's investigation into the adverse incident of an elopement that occurred on . Interviewed on at 7:30AM, Owner/Administrator stated that she could not remember whether she completed the reports. Uncorrected Class III	{A 165}		
{A 054} SS=E	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the	{A 054}		

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{A 054}	Continued From page 53 resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known [illegible] the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical [illegible], the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to maintain a Medication Observation Record (MOR) for two out of the 19 sampled residents. Findings: Observation on [illegible] at 6:23/20/2022 found medications in packs and creams for Resident #10 to include: [illegible] Tablet 1 Mg., [illegible] Tablets 20 Mg., Tablet 5 Mg., [illegible] Mes 2 Mg Tablets, [illegible] 5 Mg Tablets, 12% Lotion,	{A 054}		

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{A 054}	Continued From page 54 . . . . . 100 Mg. Tablets, 2% Cream. Observation on at 6:23 AM found two (2) empty packs for Resident #19 including Tablet 0.5 Mg., and Tablet 150 Mg., in a blue basket. A review of the MOR on showed only three residents listed in the MOR although the census was six residents. A MOR for Residents #10 and Resident #19 were not found. Interviewed on at 7:21AM, Resident #19 stated that she must go to the pharmacy to pick up her medication. Resident #19 stated further that she received medication from the staff and saw staff giving medication to all the residents. Interviewed on at 6:42AM, Resident #10 stated that he takes medication, and he never runs out of medication. Interviewed on at 7:30AM, the Owner stated that Resident #19 went without medication for the past two days and she has to go the pharmacy to pick-up her medication. Class III	{A 054}		
{A 055} SS=F	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage	{A 055}		

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{A 055}	Continued From page 55	{A 055}		

residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents.
(b) Both prescription and over-the-counter medications for residents must be centrally stored if:
1. The facility administers the medication;
2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request;
3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed;
4. The resident fails to maintain the medication in a safe manner as described in this paragraph;
5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or
6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C.
(c) Centrally stored medications must be:
1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times;
2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by

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{A 055}	Continued From page 56 being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness.	{A 055}		

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{A 055}	Continued From page 57 (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility staff failed to secure and lock the medications of the residents in a locked cabinet, cart room or storage receptacle. Findings: Observations on at 5:45AM found 2% cream in an unsecured draw in the common area. 20% prescribed for Resident #9 left in room on a shelf unsecured and unlocked. Pre-poured medication was found in the kitchen drawer in small receptacles with the names of Residents #2, #7, #9, and #10. There were also medications from a hospital to include , Tart 25 Mg, 500 unit/g 30 g, 50 Mg, 0.4 Mg, 10 Mg, 3.0 Mg, 20 Mg, 75 Mg, and . Medication for Resident #11 called Sevelamer Carb 800 Mg was left in a basket. Unsecured found in cabinets. Over-the-counter medication (Wal-), Inhalation Aerosol, Softener, and , were found in the refrigerator. A comfort kit prescribed for Resident #8 was found in the refrigerator unsecured to include , 10 Mg Suppositories, , 650 Mg, and , 100 Mg, . Medication for Resident #1 was found called 10 GM found at the bottom of the cabinet. There were medications (, 1 Mg., , 30 Mg, 100 Mg,	{A 055}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965890	A. BUILDING: _____ B. WING _____	R 06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A 055}	Continued From page 58 300 Mg, [illegible] 10 Mg, 5 Mg for Resident #20 unsecured as well. Photographic evidence obtained. Interviewed on at 6:36AM, the Owner stated, "I don't know why it was not lock it. I forgot it. I don't know why the medication were in the dryer. The medication in the Ziplock bag belong to the hospital. Sometimes they ask for it (medications) [illegible]." Class III	{A 055}		