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
	AL11969452	A. BUILDING: _____ B. WING _____	10/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBORCHASE OF DR PHILLIPS	7233 DELLA DRIVE ORLANDO, FL 32819

(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
CZ813	59A-35.090(3)(c), FAC Results of Screening & Notification In File 59A-35.090 Background Screening. (3) Results of Screening and Notification. (c) The eligibility results of employee screening and the signed Attestation referenced in subsection 59A-35.090(2), F.A.C., must be in the employee's personnel file, maintained by the provider. This Statute or Rule is not met as evidenced by: Based on personnel record review, review of the Background Screening website and interview, the facility failed to ensure that a copy of the Level 2 Background Screening (BGS) eligibility results for 1 of 13 sampled staff was maintained in the file (C). Findings: Staff C's personnel record revealed a hire date of . There were no Level 2 BGS eligibility results in the record. On at 3:30 PM, the Background Screening (BGS) website for staff C's Level 2 BGS results found that the Level 2 BGS eligibility date was . On at 10:30 AM, the Regional Director Health Wellness brought a printed copy of the Level 2 BGS eligibility results to add in the record and confirmed that she had just printed it. Unclassified	CZ813		
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening	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 Clearinghouse.- (2)(b) Until such time as the , 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 , 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; ; 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 review of the facility's employee background screening clearinghouse, personnel record reviews, and interview, the facility failed to report the employment status of 1 of 13 sampled staff within 10 business days (Administrator). Findings: Review of the facility's employee background screening clearinghouse roster on at	CZ814		

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CZ814	Continued From page 2 3:55 PM revealed the facility's administrator, who was hired on , was not listed. The finding was discussed with the Regional Director of Health and Wellness on at 4 PM. On at 5 PM, the Rgional Director of Health and Wellness provided results of a background screening for the Administrator, then said the Administrator was listed on the clearinghouse roster. Review of the background screening website revealed the facility added the Administrator to the roster on that day. The Regional Director of Health and Wellness also confirmed that finding. Unclassified	CZ814		
CZ816	408.809(2) 435.05(2) 59A-35.090(2d-3b) Background Screening-Compliance Attestation 408.809 Background screening; prohibited offenses.- (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's to the Federal Bureau of Investigation for a national criminal history record check unless the person's are enrolled in the Federal Bureau of Investigation's national retained print notification program. If the of	CZ816		

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CZ816	Continued From page 3	CZ816		

such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit [illegible] electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the [illegible] to the Federal Bureau of Investigation for a national criminal history record check. The [illegible] shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person [illegible]. The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that:
(a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section;
(b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and
(c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency.

435.05 Requirements for covered employees and

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CZ816	Continued From page 4	CZ816		

employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers:
(2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if for any of the disqualifying offenses while employed by the employer.

59A-35.090 Background Screening.
(2) Processing Screening Requests, Required Documents and Fees.
(d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, , herein incorporated by reference, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-09106, and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Regulations_Forms.shtml. This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if . . . . . for any disqualifying offense.
(e) An administrator or chief financial officer must be screened and qualified prior to , , to the position.
(3) Results of Screening and Notification.
(a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered

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CZ816	Continued From page 5 with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the report and court disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to Section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with Section 435.06(3), F.S. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interview, the facility failed to ensure 1 of 13 sampled staff completed An Attestation of Compliance with Background Screening Requirements (Administrator). Findings: Review of the Administrator's personnel record, who was hired on . . . . . , revealed the record did not contain a completed Attestation of Compliance with Background Screening Requirements. The finding was discussed with the Regional Director of Health and Wellness on . . . . . at 4 PM. On at 5 PM, the Rgional Drector of Health and Wellness said she was unable to provide a completed attestation. Unclassified	CZ816		

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A 000	Initial Comments Complaint Investigation #2022015096 was conducted on , , and . Harborchase of Dr. Phillips had deficiencies at the time of the visit.	A 000		
A 008 SS=D	429.26( ) FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner's direct observation of the patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form, reflecting the resident's condition on the date the examination is performed, becomes a permanent part of the facility's record of the resident and must be made	A 008		

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A 008	Continued From page 7	A 008		

available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6.

(6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or , , nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or her responsibilities under subsection (1). Further,

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A 008	Continued From page 8 Department of Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of [illegible] require such assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a -to- medical examination completed by a health care practitioner as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 days before or within 30 days after the individual's admission to a facility pursuant to Section 429.26(5), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations, 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living, 3. Any nursing or [illegible] services required by the individual, 4. Any special diet required by the individual, 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication, 6. Whether the individual has signs or symptoms of [illegible] or any other communicable [illegible], which are likely to be transmitted to other residents or staff, 7. A statement on the day of the examination that,	A 008		

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A 008	Continued From page 9 in the opinion of the examining health care practitioner, the individual's needs can be met in an assisted living facility; and, 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care practitioner. (b) When a health care practitioner conducts a medical examination, the examination must be recorded on the practitioner's form or on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, , , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-13531. Faxed or electronic copies of the completed form are acceptable. If AHCA Form 1823 is used, the form must be completed as instructed. 1. If the health care practitioner's form does not include all the examination items on AHCA Form 1823 or if AHCA Form 1823 is not completed fully, then the omitted items may be obtained by the administrator or designee either orally or in writing from the health care practitioner. The missing or omitted information must be obtained and documented in the resident's record within 30 days after the resident's admission to the facility. 2. Omitted or missing information received orally must include the name of the health care practitioner, the name and signature of the administrator or designee recording the information, and the date the information was provided. (c) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b).	A 008		

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A 008	Continued From page 10 (d) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.26, F.S. and this rule. (e) Any orders issued by the health care practitioner conducting the medical examination for medications, nursing services, treatments, , , or therapeutic diets, may be attached to the health assessment. A health care practitioner may attach a DH Form 1896, Florida Form, for residents who do not wish to be administered in the case of or . (f) A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on resident record review and interview, the facility failed to obtain a signed and dated admission 1823 Health Assessment, AHCA Form completed by the healthcare provider for 1 of 4 sampled residents (#3). Findings:	A 008		

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A 008	Continued From page 11 Resident #3's record revealed an admission date of . The last 1823 Health Assessment, dated , listed a medical history of with behavioral disturbances, , legally , and , . Her cognition status was alert with , memory loss, poor judgement and aggressive when agitated. She was independent with ambulation, eating, toileting, transferring, required supervision with bathing, , grooming, and needed assistance with self-administration of medications. Photographic evidence was obtained. There was no documented evidence of the original admission 1823 Health Assessment in the file when reviewed. On at 2:30 PM, the Regional Director of Health and Wellness brought a faxed copy of the original 1823 AHCA Health Assessment not signed and not dated by the healthcare provider but had an attached physician's note of the supposed date. Photographic evidence was obtained. On at 4 PM, an interview with the Regional Director of Health and Wellness confirmed the finding. Class III	A 008		
A 025 SS=G	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	A 025		

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A 025	Continued From page 12 in order to rule out the presence of an underlying physiological condition that may be contributing to such [illegible] or [illegible]. 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 [illegible] for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 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	A 025		

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A 025	Continued From page 13 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 reviews and interviews, the facility failed to notify the responsible party and health care provider when an investigation was conducted into allegations of misconduct involving 1 of 4 sampled residents (#4), and failed to document in 1 of 4 sampled resident's record when the resident was taken to the hospital and when a delay occurred following a health care provider's order for a , (. .) test (#3). Findings: 1.Review of investigation notes, authored by the Human Resource Consultant and dated , revealed that Caregiver G alleged misconduct between Staff A and resident #4 sometime during . The notes did not indicate the resident's responsible party and healthcare provider were notified when the investigation was conducted. Review of an email correspondence, authored by previous Administrator J, dated , revealed that at that point in the investigation, administration believed that Caregiver G's , was very accurate, credible and she	A 025		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBORCHASE OF DR PHILLIPS	7233 DELLA DRIVE ORLANDO, FL 32819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 14	A 025		

seemed to be genuine in her concern for resident #4. Staff A seemed to have conflicting , but did have some credible excuses. The notes did not indicate the resident's responsible party and healthcare provider were notified when the investigation was conducted.

Resident #4's record review revealed an admission date of and was discharged to a higher level of care on . The last 1823 Health Assessment, dated , listed a medical history including Inflammatory , , and . She needed assistance with ambulation, bathing, toileting, and transferring. Independent with eating and grooming. She was able to administer her own medications. Photographic evidence was obtained.

On at 10:42 AM, the Regional Director of Operations said she did not know if the resident's responsible party and the health care provider were notified of the investigation that took place involving staff A and resident #4. On at 12:04 PM, the Director of Health and Wellness said she was familiar with the incident and subsequent investigation involving resident #4 and staff A. She said both the resident's responsible party and health care provider were notified and that she would provide documentation of the notifications.

On at 3:29 PM, the Director of Health and Wellness said she could not locate any documentation of notification to the responsible party and a health care provider regarding the investigation involving resident #4.

On at 4:20 PM, resident #4's Health Care Surrogate said that no one from the facility

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A 025	Continued From page 15	A 025		

notified her in , when the investigation was conducted into misconduct between staff A and the resident. She said she learned from resident #4's friends of interactions that occurred between the two, then later read notes on resident #4's phone where the interactions were documented by the resident. The Health Care Surrogate said she did not share what she learned with the facility staff.

2. A facility report, dated at 4:10 PM, was received by the Agency for Health Care Administration (AHCA) that staff A had interaction with resident #3.

Resident #3's record revealed an admission date of into the facility. The last 1823 Health Assessment, dated , listed a medical history of with behavioral disturbances, , legally , and , . Her cognition status was alert with , memory loss, poor judgement and aggressive when agitated. She was independent with ambulation, eating, toileting, transferring, required supervision with bathing, , and grooming, and needed assistance with self-administration of medications. Photographic evidence was obtained.

A , note, dated on , added an onset of Schizophreniform to resident #3's medical history. "Schizophreniform is a type of , illness with symptoms similar to those of , but lasting for less than 6 months." (Retrieved www.webMD.com). Photographic evidence was obtained.1.

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A 025	Continued From page 16 Resident #3's record contained a healthcare provider order, dated on , for the resident to have a test performed. The resident's record did not contain documentation to indicate the test was done. On at 11:51 AM, resident #3 was asked about interactions with staff A on . She explained that staff A was her boyfriend and best friend. She stated that her husband would often ask staff A to check on her because they were friends, and she was legally . She stated she and staff A had consensual . Resident #3 recalled that DCF and the Police came and asked her if staff A forced himself on her or took advantage of her. Resident #3 provided the DCF card and case number left with her. Resident #3 stated that she told both DCF and the Police that it was consensual and was not pressing any charges because she and staff A had multiple times before in her apartment. On at 1:05 PM, the Director of Nursing (DON) said that on at approximately 12 PM, she and the current Administrator took resident #3 to the hospital for a test. When asked why the resident was not taken for the test until , the DON said she did not know why. She confirmed the resident's record did not contain documentation to indicate the resident was taken to hospital and then returned from the hospital. On at 12:23 PM, the DON returned and said the reason resident #3 was not taken to the hospital for the test until was because the resident was difficult and had a history of refusing to go to .	A 025		

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A 025	Continued From page 17 Review of the facility's Resident . . . . . Policy, dated , the policy indicated that "The Administrator or Supervisor on duty should notify the resident's legally responsible party and physician and that the notifications should be documented in the resident's progress notes." Class II	A 025		
A 030 SS=J	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,	A 030		

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A 030	Continued From page 18 1(800)96- . . . . or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident . . . . , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. . . . . control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which	A 030		

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A 030	Continued From page 19 residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from 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	A 030		

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A 030	Continued From page 20 representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care ., , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally ., the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal	A 030		

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A 030	Continued From page 21	A 030		

representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.

(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.

(2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that

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A 030	Continued From page 22 retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder . . . . . Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated . . . , . . . or . . . , ... under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on the facility's documentation, resident record reviews, and interviews, the facility failed to ensure the residents lived in a safe environment free from . . . . . and allowed staff A, who had a previous allegation of inappropriate . . . . . interaction with a resident (#4) and allowed staff A to continue employment for 45	A 030		

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days before the staff member who witnessed the interaction reported the incident to the administrator. Staff A was allowed to remain employed at the facility until , placing residents at risk for . One hundred fifty-three days later, staff A had a second interaction with another resident (#3), who had a diagnosis of .

Findings:

1. A facility report, dated at 4:10 PM, was received by the Agency for Health Care Administration (AHCA) that Staff A had an inappropriate interaction with resident #3.

Resident #3's record revealed an admission date of into the facility. The most recent 1823 Health Assessment dated listed medical history including with behavioral disturbances, , Legally , and , . Her cognition status was alert with , memory loss, poor judgement and aggressive when agitated. She was independent with ambulation, eating, toileting, transferring. The resident required supervision with bathing, , grooming, and the resident needed assistance with self-administration of medications. Photographic evidence was obtained.

A , note dated on , added an onset of Schizophreniform to resident #3's medical history. "Schizophreniform is a type of , , illness with symptoms similar to those of , but lasting for less than 6 months." (Retrieved www.webMD.com). Photographic evidence was obtained.

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A 030	Continued From page 24 On at 11:51 AM, resident #3 was asked about interactions with staff A on . She explained that staff A was her boyfriend and best friend. She stated that her husband would often ask staff A to check on her because they were friends, and she was legally . She stated she and staff A had consensual . Resident #3 recalled that DCF and the Police came and asked her if staff A forced himself on her or took advantage of her. Resident #3 provided the DCF card and case number left with her. Resident #3 stated that she told both DCF and the Police that it was consensual and was not pressing any charges because she and staff A had multiple times before in her apartment. Resident #3 recalled that the Department of Children and Families (DCF) and the Police came to visit her about the interaction to make sure Staff A did not take advantage of her or force her into conducting the interaction. The resident said her husband knew that she and Staff A had interactions. Resident #3 stated that she was very upset with the woman (unknown name) who reported this incident to everyone. Resident #3 stated she knew Staff A no longer worked at the facility because of the woman (unknown name) who reported them, but she said that Staff A had told her that he wanted to quit anyway. Resident #3 also said Staff A can now come visit her and come pick her up to escort her to her doctor and other outings since he no longer worked at the facility. On at 1 PM, the Director of Nursing (DON) stated that resident #3's husband was and that resident #3 had with . The DON stated she was very concerned and alarmed about the	A 030		

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A 030	Continued From page 25 interaction between resident #3 and Staff A when Caregiver B reported it to her. The DON said she interviewed resident #3 after it was reported to her by Caregiver B. The DON stated resident #3 admitted to her that Staff A "was in her room doing adult activities". The DON further stated that she thought resident #3 was a . . . . . adult being taken advantage of by Staff A on . . . . . and that was why she initiated and submitted the report to AHCA. On at 3 PM, the Regional Director of Operations and the National Health Wellness Director confirmed that they both called Staff A on . . . . . approximately at 10 PM to let him know what allegation was brought against him, and they were suspending him pending further investigation. The Regional Director of Operations also stated that she attempted to call Staff A twice on and , but there was no answer. Several voicemail messages were left. Staff A never returned the telephone calls but had someone drop off his phone and keys to the facility on . She later confirmed staff A was terminated on . On at 4:52 PM via telephone, Staff A said he was not aware of allegations made against him concerning resident #3. Staff A said that on . . . . . at approximately 10 PM after working his regular shift earlier that day, he received a telephone call from the Divisional Vice President and the National Health Wellness Director stating there was an . . . . . allegation against him pending further investigation and he was suspended. Staff A denied knowing the reason for the suspension and exact reason of the allegations. Staff A was told that he was named for having . interactions with	A 030		

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A 030	Continued From page 26 resident #3 and that the resident told different staff that she had with him. Staff A said he did not know why resident #3 said this but maybe because he was very charismatic with all the residents and took extra time out to speak to them nicely and tell the residents how nice they looked. Maybe the resident may have taken it the wrong way. Staff A said he did not know that another staff had seen him in resident #3's room. Staff A denied that he was ever in the resident's room except to deliver food and drinks. He stated that resident #3 told him that he reminded her of her late husband, and that resident #3 would see him in the dining room and grab, touch, and tug on him. Staff A stated that he also witnessed previously that resident #3 would make remarks to another male coworker who worked at the facility. Staff A stated that he was done dealing with the facility and would not return after this investigation and that he submitted his resignation letter about 45 days ago with his last day to be , the same day of the allegation. Staff A stated that he completed his , neglect, and , training and read the facility's policy. Staff A's personnel record revealed a hire date of , and he was terminated on . Staff A's level 2 Background Screening eligibility was dated . There was no documented evidence of the , neglect, and , training completion. On at 12:15 PM, resident #3's Health Care Surrogate said resident #3 had and was deemed by her physician to be , to make decisions. The Health Care Surrogate said that she did not believe resident #3 was cognizant to have given consent for a relationship with Staff A.	A 030		

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A 030	Continued From page 27 Review of a health care provider's Statement of Incapacity, dated , revealed documentation that indicated resident #3 lived in a memory care unit at the time of the exam. The resident had with and poor memory. She had significant loss of sight and was legally . She required assistance for all aspects of her care and assistance in making personal, financial, and legal decisions. On at 1 PM, nurse E said she examined resident #3 following the incident of alleged misconduct between the resident and Staff A and that during her exam, the resident was shaken up and said that she did not know who to trust. The nurse said the resident was normally and that the examination resulted in not finding any visible injuries to the resident. On at 1:05 PM, the DON said that on at approximately 12 PM, she and the current administrator took resident #3 to the hospital for a ( ) test that was ordered by the resident's health care provider on . When asked why the resident was not taken for the test on the day of the order, the DON said she did not know why. She confirmed the resident's record did not contain documentation to indicate the resident was taken to then returned from the hospital. On at 1:10 PM, resident #3's Health Care Provider said he visited with the resident on due to the reported allegation of misconduct but, that he did not ask the resident anything about the incident during the visit. He said he ordered the test only because the resident's Health Care Surrogate requested the test. He said that during the visit, the resident was	A 030		

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A 030	Continued From page 28 her usual self. He said the resident had , and forgetfulness due to , but she did not look troubled and was otherwise capable of giving consent for what happened. On at 2:11 PM, Caregiver B said that on at approximately 4 PM, she went to resident #3's room to take the resident's dinner order. The main room door was closed and locked, which she found unusual because the resident usually kept the door open. She used her key to enter the room then saw the resident's room door was closed. She called out to the resident, who replied "I'm okay, I'm okay". She then told the resident she was there to take a dinner order at which time, the resident quickly responded, "chicken cutlet, chicken cutlet". She also found that odd but thought perhaps another male resident was in the bedroom because she had previously seen the resident and a male resident kissing in the resident's living room. When she exited the room, she left the door ajar. She then walked a short way down the hall then turned around and as she passed #3's room, she saw Staff A standing in the resident's living room. She stopped at another resident's room to say hello and when she reentered the hallway, Staff A walked toward her from the direction of resident #3's room. She immediately went to Caregiver C and told him what she saw, then asked him to not tell anyone else. Shortly thereafter she learned that he told Caregiver D, so she decided to text the DON and ask to meet with her about what she saw. On at 2:43 PM, Caregiver D said that on , Caregiver C told her about resident #3 and Staff A. She then went to speak with the resident, and later said that something weird was going on. She said the resident was normally	A 030		

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A 030	Continued From page 29 On at 3:27 PM, Caregiver C said that on at approximately 4 PM, he was standing at the medication cart when Caregiver B approached him and reported what she saw in resident #3's room. He went to the resident's room and asked her if there had been a man visiting with her, and she said "yes" and described the man as her friend. When he asked her if the man was a worker at the facility, she laughed then responded, "He's not a worker, he's a supervisor." When he asked her what they were doing, she responded "adult activities". He said that on two previous occasions he walked into resident #3's room and found the resident and another male resident lying naked together on resident #3's sofa. On at 10:05 AM via telephone, the DCF investigator revealed that she had concerns about resident #3 consenting to a encounter with Staff A because resident #3 was an older female with . The investigator stated the DCF case was pending upon receipt of official police report. It was also explained that during AHCA's investigation, it was discovered that another female victim had a encounter at the facility with Staff A in . It was reported by Caregiver G in . The facility never called DCF and reported that encounter as required. On at 12:23 PM, the DON said the reason resident #3 was not taken to the hospital for the test until was because the resident was difficult and had a history of refusing to go to but did not indicate if the resident refused to have the test done on , as ordered.	A 030		

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A 030	Continued From page 30 2. Review of investigation notes, authored by the human resource consultant and dated [redacted], revealed that caregiver G alleged misconduct between staff A and resident #4 that occurred sometime during [redacted]. Review of an email correspondence, authored by the previous administrator J and dated [redacted], revealed that at that point in the investigation, the administration believed that caregiver G's [redacted], was very accurate, credible and she seemed to be genuine in her concern for resident #4. Staff A seemed to have conflicting [redacted], but did have some credible excuses. Review of a document, authored by the previous administrator J and dated [redacted], revealed that at the conclusion of the investigation, the facility determined that there was insufficient evidence to support the allegation and an expectation was set forth that staff A would refrain from any and all interactions with resident #4 only while she was in her room. Resident #4's record review revealed an admission date of [redacted] and was discharged to a higher level of care on [redacted]. The last 1823 Health Assessment dated [redacted] list included a medical history of [redacted] Inflammatory [redacted], and [redacted]. She needs assistance with ambulation, bathing, [redacted], toileting, and transferring, was independent with eating and grooming, and was able to administer her own medications. Photographic evidence was obtained. On [redacted] at 4:33 PM via telephone, caregiver G confirmed that she observed Staff A coming out of resident #4's room disheveled and	A 030		

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A 030	Continued From page 31 fixing his clothes. Caregiver G stated that she observed this a few minutes later when resident #4 had called for assistance with a shower on or about . She could not remember the exact date. Caregiver G went to resident #4's room to help her with a shower and get ready for bed. Caregiver G said the resident told her she just had a interaction. Caregiver G stated that she did not report this because resident #4 asked her not to say anything, and did not want to get involved, but after thinking about it later, Caregiver G stated that she told the previous Administrator J on or about , after she had reported it to Nurse I. On at 4:52 PM via telephone, Staff A said he was told that he was named for having interactions with resident #4 and that the resident told different staff that she had with him. Staff A said he did not know why the resident said this but maybe because he was very charismatic with all the residents and took extra time out to speak to them nicely and tell the residents how nice they looked. Maybe resident # have taken it the wrong way. Staff A said he did not know that another staff had seen him coming out of resident #4s room in . Staff A denied that he was ever in the resident's room except to deliver food and drinks. Staff A was told that resident #4 asked Caregiver G to assist her with a shower a few minutes after seeing staff A coming out of resident #4's room. Caregiver G said Staff A was disheveled and seen fixing his clothes. Staff A denied that claim. Staff A stated he went through an investigation regarding resident #4 in . Staff A stated the previous Administrator J was told by the DON that an incident of conduct had been reported and brought to their attention. Staff A stated he also had to speak with the facility's	A 030		

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A 030	Continued From page 32 attorney, also known as the Human Resources Consultant. The findings were deemed inconclusive, and he returned to work. Staff A stated that he completed his , neglect, and training and read the facility's policy. On at 10 AM, the Human Resource Consultant said that following the investigation into the incident involving resident #4 and Staff A, it was determined that there was no evidence to confirm that Staff A had a encounter with resident #4. He said that at the conclusion of the investigation, Staff A was no longer allowed to have any interactions with resident #4 in her room. He did not know whether the allegation was reported to DCF. On at 10:42 AM, the Regional Director of Operations said she did not know if DCF, the resident's responsible party, and the resident's health care provider were notified of the investigation that took place involving Staff A and resident #4. She also did not know if training for staff was conducted following the investigation and whether any disciplinary action and training occurred specifically for Caregiver G, who failed to follow the facility's policy by not immediately reporting the allegation. On at 11:25 AM, Caregiver G said she did not report the incident until in because she didn't want to get involved with anything. Caregiver G explained that after she saw Staff A leaving resident #4's room, observed 3 bottles of wine were on the counter in resident #4's room. Caregiver G said resident #4 stated that she requested it and her friend, Staff A, brought it up to her. While Caregiver G assisted resident #4 with a shower, resident #4 told her	A 030		

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A 030	Continued From page 33	A 030		

that she just had . Caregiver G confirmed that she had the training and read over the facility's policy but agreed that she did not report any allegations observed or suspected immediately concerning interaction between Staff A and resident #4.
On at 11:33 AM, Nurse I said that although she could not remember the date, she did recall that Caregiver G called her and said that she saw Staff A take drinking into resident #4's room then exiting the -40 minutes later. Nurse, I said that during the same week of hearing from Caregiver G, she was in a meeting with the Director of Nursing (DON) when she reported what Caregiver G alleged. Nurse, I said following the investigation, she received training on the facility's resident policy, including steps on reporting suspected .

On at 12:04 PM, the Director of Health and Wellness said she was familiar with the incident and subsequent investigation involving resident #4 and Staff A. She said DCF and both the resident's responsible party and health care provider were notified and that she would provide documentation of the notifications.

On at 1:05 PM, the DON confirmed that Nurse, I told her during a meeting, the date of which she could not remember, what Caregiver G alleged regarding Staff A and resident #4.

On at 3:27 PM, Caregiver C said there was one previous time he saw Staff A kiss resident #4 on the cheek while they were both in the dining room.

On at 3:29 PM, the Director of Health and Wellness said she could not locate any documentation of notification to DCF, responsible

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A 030	Continued From page 34 party and a health care provider regarding the investigation involving resident #4. On at 4:20 PM, resident #4's Health Care Surrogate said that no one from the facility notified her in , when the investigation was conducted into misconduct between Staff A and the resident. She said she learned from resident #4's friends of interactions that occurred between the two later when she read notes on resident #4's phone where the interactions were documented by the resident. The Health Care Surrogate said she did not share what she learned with facility staff. On at 11:50 AM, the Director of Hospitality and Staff A's supervisor said that Staff A's duties included scheduling, assisting with serving meals, food delivery to resident rooms and bartending. He said that following the , investigation involving resident #4, Staff A was prohibited only from going into resident #4's room. On at 12:28 PM, previous Administrator J said that his investigation into the allegation involving resident #4 and Staff A found no proof that Staff A had an inappropriate interaction with the resident and that Staff A denied the allegation. He said that at the conclusion of the investigation, Staff A was prohibited from going into resident #4's room and that he merely suggested to Staff A to not enter any other resident's room. Review of the facility's Resident Policy, which was dated , revealed the policy indicated that any employee who witnessed or became aware of alleged , neglect, or , , should report such incident to the administrator or supervisor on duty immediately.	A 030		

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A 030	Continued From page 35 The policy also indicated that the administrator or supervisor on duty should notify the resident's legally responsible party and physician and that the notifications should be documented in the resident's progress notes. The facility did not follow its policy and procedure for neglect and . When the . . . . interaction occurred with resident #4, the facility did not do the following: 1. Conduct a thorough investigation 2. The facility did not protect the residents by suspending staff A pending outcome of the investigation. 3. The facility did not report the . . . . interaction to the Department of Children and Families as required 4. The facility did not conduct in-service training to re-education staff on the facility's policy and procedures for and neglect. 5. Seven of the staff sampled did not have documentation they received training in the facility's policy for . . . . , neglect, and Based on the investigation by AHCA, the facility did not put any measures in place to prevent the occurrence of the interaction by staff A with resident #4 on . . . . . This interaction was not reported until 45 days after the interaction occurred, on . . . . . A second interaction by staff A with resident #3 occurred on . . . . . , approximately six and a half months after the first interaction. The facility allowed staff A to remain employed at the facility, thus allowing the residents to be placed at risk for re-occurrence of . . . . interaction. It was not until the second occurrence that staff A was terminated on , five days after the second interaction with resident #3.	A 030		

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A 030	Continued From page 36 Class I	A 030		
A 077 SS=J	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an 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	A 077		

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A 077	Continued From page 37 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 ; 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,	A 077		

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A 077	Continued From page 38 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a 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.	A 077		

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A 077	Continued From page 39 This Statute or Rule is not met as evidenced by: Based on the facility's documentation, personnel record review and interviews, the facility 1. Failed to have an Administrator that was in control for the responsibility of operations, including management to ensure that appropriate care for 2 of 4 sampled residents (#3 & #4) was provided after knowingly aware of interaction that occurred by an employee (A). 2. Failed to notify the responsible party and health care provider when an investigation was conducted into allegations of misconduct involving 1 of 4 sampled residents (#4) and failed to document in 1 of 4 sampled resident's record when the resident was taken to the hospital and when a delay occurred following a health care provider's order for a ( ) test (#3). 3. Failed to ensure 7 of 13 sampled staff received a minimum of 1-hour in-service training within 30 days of employment that covered resident rights in an assisted living facility and, with the use of the facility's prevention policies and procedures, training on recognizing and reporting resident , neglect, and (A, B, C, D, E, G & H). 4. Failed to notify Department of Children and Families (DCF) when there was an allegation of misconduct involving 1 of 13 sampled staff (A) and 1 of 4 sampled residents (#4). Findings: 1. A facility report, dated at 4:10 PM, was received by the Agency for Health Care Administration (AHCA) that Staff A had an inappropriate interaction with resident #3.	A 077		

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A 077	Continued From page 40 Resident #3's record revealed an admission date of into the facility. The most recent 1823 Health Assessment dated listed medical history including with behavioral disturbances, , Legally , and , . Her cognition status was alert with , memory loss, poor judgement and aggressive when agitated. She was independent with ambulation, eating, toileting, transferring. The resident required supervision with bathing, , grooming, and the resident needed assistance with self-administration of medications. Photographic evidence was obtained. A , , note dated on , added an onset of Schizophreniform to resident #3's medical history. "Schizophreniform is a type of , , illness with symptoms similar to those of , but lasting for less than 6 months." (Retrieved www.webMD.com). Photographic evidence was obtained. On at 11:51 AM, resident #3 was asked about interactions with staff A on . She explained that staff A was her boyfriend and best friend. She stated that her husband would often ask staff A to check on her because they were friends, and she was legally . She stated she and staff A had consensual . Resident #3 recalled that DCF and the Police came and asked her if staff A forced himself on her or took advantage of her. Resident #3 provided the DCF card and case number left with her. Resident #3 stated that she told both DCF and the Police that it was consensual and was not pressing any charges because she and staff A had multiple times before in her apartment. Resident #3 recalled that the	A 077		

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A 077	Continued From page 41 Department of Children and Families (DCF) and the Police came to visit her about the interaction to make sure Staff A did not take advantage of her or force her into conducting the interaction. The resident said her husband knew that she and Staff A had interactions. Resident #3 stated that she was very upset with the woman (unknown name) who reported this incident to everyone. Resident #3 stated she knew Staff A no longer worked at the facility because of the woman (unknown name) who reported them, but she said that Staff A had told her that he wanted to quit anyway. Resident #3 also said Staff A can now come visit her and come pick her up to escort her to her doctor , , and other outings since he no longer worked at the facility. On at 1 PM, the Director of Nursing (DON) stated that resident #3's husband was and that resident #3 had with . The DON stated she was very concerned and alarmed about the interaction between resident #3 and Staff A when Caregiver B reported it to her. The DON said she interviewed resident #3 after it was reported to her by Caregiver B. The DON stated resident #3 admitted to her that Staff A "was in her room doing adult activities". The DON further stated that she thought resident #3 was a adult being taken advantage of by Staff A on and that was why she initiated and submitted the report to AHCA. On at 3 PM, the Regional Director of Operations and the National Health Wellness Director confirmed that they both called Staff A on approximately at 10 PM to let him know what allegation was brought against him, and they were suspending him pending further	A 077		

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A 077	Continued From page 42 investigation. The Regional Director of Operations also stated that she attempted to call Staff A twice on [redacted] and [redacted], but there was no answer. Several voicemail messages were left. Staff A never returned the telephone calls but had someone drop off his phone and keys to the facility on [redacted]. She later confirmed staff A was terminated on [redacted]. On [redacted] at 4:52 PM via telephone, Staff A said he was not aware of allegations made against him concerning resident #3. Staff A said that on [redacted] at approximately 10 PM after working his regular shift earlier that day, he received a telephone call from the Divisional Vice President and the National Health Wellness Director stating there was an [redacted] allegation against him pending further investigation and he was suspended. Staff A denied knowing the reason for the suspension and exact reason of the allegations. Staff A was told that he was named for having [redacted] interactions with resident #3 and that the resident told different staff that she had [redacted] with him. Staff A said he did not know why resident #3 said this but maybe because he was very charismatic with all the residents and took extra time out to speak to them nicely and tell the residents how nice they looked. Maybe the resident may have taken it the wrong way. Staff A said he did not know that another staff had seen him in resident #3's room. Staff A denied that he was ever in the resident's room except to deliver food and drinks. He stated that resident #3 told him that he reminded her of her late husband, and that resident #3 would see him in the dining room and grab, touch, and tug on him. Staff A stated that he also witnessed previously that resident #3 would make remarks to another male coworker who worked at the	A 077		

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A 077	Continued From page 43	A 077		

facility. Staff A stated that he was done dealing with the facility and would not return after this investigation and that he submitted his resignation letter about 45 days ago with his last day to be , the same day of the allegation. Staff A stated that he completed his , neglect, and , training and read the facility's policy.

Staff A's personnel record revealed a hire date of , and he was terminated on . Staff A's level 2 Background Screening eligibility was dated . There was no documented evidence of the , neglect, and , training completion.

On at 12:15 PM, resident #3's Health Care Surrogate said resident #3 had and was deemed by her physician to be , to make decisions. The Health Care Surrogate said that she did not believe resident #3 was cognizant to have given consent for a relationship with Staff A.

Review of a health care provider's Statement of Incapacity, dated , revealed documentation that indicated resident #3 lived in a memory care unit at the time of the exam. The resident had with and poor memory. She had significant loss of sight and was legally . She required assistance for all aspects of her care and assistance in making personal, financial, and legal decisions.

On at 1 PM, nurse E said she examined resident #3 following the incident of alleged misconduct between the resident and Staff A and that during her exam, the resident was shaken up and said that she did not know who to trust. The nurse said the resident was normally

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A 077	Continued From page 44 and that the examination resulted in not finding any visible injuries to the resident. On at 1:05 PM, the DON said that on at approximately 12 PM, she and the current administrator took resident #3 to the hospital for a ( ) test that was ordered by the resident's health care provider on . When asked why the resident was not taken for the test on the day of the order, the DON said she did not know why. She confirmed the resident's record did not contain documentation to indicate the resident was taken to then returned from the hospital. On at 1:10 PM, resident #3's Health Care Provider said he visited with the resident on due to the reported allegation of misconduct but, that he did not ask the resident anything about the incident during the visit. He said he ordered the test only because the resident's Health Care Surrogate requested the test. He said that during the visit, the resident was her usual self. He said the resident had and forgetfulness due to , but she did not look troubled and was otherwise capable of giving consent for what happened. On at 2:11 PM, Caregiver B said that on at approximately 4 PM, she went to resident #3's room to take the resident's dinner order. The main room door was closed and locked, which she found unusual because the resident usually kept the door open. She used her key to enter the room then saw the resident's room door was closed. She called out to the resident, who replied "I'm okay, I'm okay". She then told the resident she was there to take a dinner order at which time, the resident quickly responded, "chicken cutlet, chicken cutlet". She	A 077		

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A 077	Continued From page 45 also found that odd but thought perhaps another male resident was in the bedroom because she had previously seen the resident and a male resident kissing in the resident's living room. When she exited the room, she left the door ajar. She then walked a short way down the hall then turned . . . around and as she passed #3's room, she saw Staff A standing in the resident's living room. She stopped at another resident's room to say hello and when she reentered the hallway, Staff A walked toward her from the direction of resident #3's room. She immediately went to Caregiver C and told him what she saw, then asked him to not tell anyone else. Shortly thereafter she learned that he told Caregiver D, so she decided to text the DON and ask to meet with her about what she saw. On . . . . . at 2:43 PM, Caregiver D said that on . . . . . , Caregiver C told her about resident #3 and Staff A. She then went to speak with the resident, and later said that something weird was going on. She said the resident was normally On . . . . . at 3:27 PM, Caregiver C said that on . . . . . at approximately 4 PM, he was standing at the medication cart when Caregiver B approached him and reported what she saw in resident #3's room. He went to the resident's room and asked her if there had been a man visiting with her, and she said "yes" and described the man as her friend. When he asked her if the man was a worker at the facility, she laughed then responded, "He's not a worker, he's a supervisor." When he asked her what they were doing, she responded "adult activities". He said that on two previous occasions he walked into resident #3's room and found the resident and another male resident lying naked together on	A 077		

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A 077	Continued From page 46 resident #3's sofa. On [redacted] at 10:05 AM via telephone, the DCF investigator revealed that she had concerns about resident #3 consenting to a [redacted] encounter with Staff A because resident #3 was an older [redacted] female with [redacted]. The investigator stated the DCF case was pending upon receipt of official police report. It was also explained that during AHCA's investigation, it was discovered that another [redacted] female victim had a [redacted] encounter at the facility with Staff A in [redacted]. It was reported by Caregiver G in [redacted]. The facility never called DCF and reported that encounter as required. On [redacted] at 12:23 PM, the DON said the reason resident #3 was not taken to the hospital for the [redacted] test until [redacted] was because the resident was difficult and had a history of refusing to go to [redacted] but did not indicate if the resident refused to have the test done on [redacted], as ordered. 2. Review of investigation notes, authored by the human resource consultant, and dated [redacted], revealed that caregiver G alleged [redacted] misconduct between staff A and resident #4 that occurred sometime during [redacted]. Review of an email correspondence, authored by the previous administrator J and dated [redacted], revealed that at that point in the investigation, the administration believed that caregiver G's [redacted], was very accurate, credible and she seemed to be genuine in her concern for resident #4. Staff A seemed to have conflicting [redacted], but did have some credible excuses. Review of a document, authored by the previous	A 077		

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A 077	Continued From page 47	A 077		

administrator J and dated [redacted], revealed that at the conclusion of the investigation, the facility determined that there was insufficient evidence to support the allegation and an expectation was set forth that staff A would refrain from any and all interactions with resident #4 only while she was in her room.

Resident #4's record review revealed an admission date of [redacted] and was discharged to a higher level of care on [redacted]. The last 1823 Health Assessment dated [redacted] list included a medical history of [redacted] Inflammatory [redacted], and [redacted]. She needs assistance with ambulation, bathing, [redacted], toileting, and transferring, was independent with eating and grooming, and was able to administer her own medications. Photographic evidence was obtained.

On [redacted] at 4:33 PM via telephone, caregiver G confirmed that she observed Staff A coming out of resident #4's room disheveled and fixing his clothes. Caregiver G stated that she observed this a few minutes later when resident #4 had called for assistance with a shower on or about [redacted]. She could not remember the exact date. Caregiver G went to resident #4's room to help her with a shower and get ready for bed. Caregiver G said the resident told her she just had a [redacted] interaction. Caregiver G stated that she did not report this because resident #4 asked her not to say anything, and did not want to get involved, but after thinking about it later, Caregiver G stated that she told the previous Administrator J on or about [redacted], after she had reported it to Nurse I.

On [redacted] at 4:52 PM via telephone, Staff A said he was told that he was named for having

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A 077	Continued From page 48 . . . . interactions with resident #4 and that the resident told different staff that she had with him. Staff A said he did not know why the resident said this but maybe because he was very charismatic with all the residents and took extra time out to speak to them nicely and tell the residents how nice they looked. Maybe resident # , have taken it the wrong way. Staff A said he did not know that another staff had seen him coming out of resident #4s room in . Staff A denied that he was ever in the resident's room except to deliver food and drinks. Staff A was told that resident #4 asked Caregiver G to assist her with a shower a few minutes after seeing staff A coming out of resident #4's room. Caregiver G said Staff A was disheveled and seen fixing his clothes. Staff A denied that claim. Staff A stated he went through an investigation regarding resident #4 in , ... Staff A stated the previous Administrator J was told by the DON that an incident of . . . . conduct had been reported and brought to their attention. Staff A stated he also had to speak with the facility's attorney, also known as the Human Resources Consultant. The findings were deemed inconclusive, and he returned to work. Staff A stated that he completed his . . . . , neglect, and , training and read the facility's policy. On . . . . . at 10 AM, the Human Resource Consultant said that following the investigation into the incident involving resident #4 and Staff A, it was determined that there was no evidence to confirm that Staff A had a . . . . encounter with resident #4. He said that at the conclusion of the investigation, Staff A was no longer allowed to have any interactions with resident #4 in her room. He did not know whether the allegation was reported to DCF.	A 077		

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A 077	Continued From page 49 On at 10:42 AM, the Regional Director of Operations said she did not know if DCF, the resident's responsible party, and the resident's health care provider were notified of the investigation that took place involving Staff A and resident #4. She also did not know if . . . . . training for staff was conducted following the investigation and whether any disciplinary action and training occurred specifically for Caregiver G, who failed to follow the facility's . . . . . policy by not immediately reporting the allegation. On at 11:25 AM, Caregiver G said she did not report the incident until in . . . . . because she didn't want to get involved with anything. Caregiver G explained that after she saw Staff A leaving resident #4's room, observed 3 bottles of wine were on the counter in resident #4's room. Caregiver G said resident #4 stated that she requested it and her friend, Staff A, brought it up to her. While Caregiver G assisted resident #4 with a shower, resident #4 told her that she just had . Caregiver G confirmed that she had the . . . . . training and read over the facility's policy but agreed that she did not report any allegations observed or suspected immediately concerning interaction between Staff A and resident #4. On . . . . . at 11:33 AM, Nurse I said that although she could not remember the date, she did recall that Caregiver G called her and said that she saw Staff A take drinking into resident #4's room then exiting the . . . . . -40 minutes later. Nurse, I said that during the same week of hearing from Caregiver G, she was in a meeting with the Director of Nursing (DON) when she reported what Caregiver G alleged. Nurse, I said following the investigation, she received	A 077		

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A 077	Continued From page 50 training on the facility's resident policy, including steps on reporting suspected . On at 12:04 PM, the Director of Health and Wellness said she was familiar with the incident and subsequent investigation involving resident #4 and Staff A. She said DCF and both the resident's responsible party and health care provider were notified and that she would provide documentation of the notifications. On at 1:05 PM, the DON confirmed that Nurse, I told her during a meeting, the date of which she could not remember, what Caregiver G alleged regarding Staff A and resident #4. On at 3:27 PM, Caregiver C said there was one previous time he saw Staff A kiss resident #4 on the cheek while they were both in the dining room. On at 3:29 PM, the Director of Health and Wellness said she could not locate any documentation of notification to DCF, responsible party and a health care provider regarding the investigation involving resident #4. On at 4:20 PM, resident #4's Health Care Surrogate said that no one from the facility notified her in , when the investigation was conducted into misconduct between Staff A and the resident. She said she learned from resident #4's friends of interactions that occurred between the two later when she read notes on resident #4's phone where the interactions were documented by the resident. The Health Care Surrogate said she did not share what she learned with facility staff. On at 11:50 AM, the Director of	A 077		

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A 077	Continued From page 51 Hospitality and Staff A's supervisor said that Staff A's duties included scheduling, assisting with serving meals, food delivery to resident rooms and bartending. He said that following the investigation involving resident #4, Staff A was prohibited only from going into resident #4's room. On at 12:28 PM, previous Administrator J said that his investigation into the allegation involving resident #4 and Staff A found no proof that Staff A had an inappropriate interaction with the resident and that Staff A denied the allegation. He said that at the conclusion of the investigation, Staff A was prohibited from going into resident #4's room and that he merely suggested to Staff A to not enter any other resident's room. Review of the facility's Resident Policy, which was dated , revealed the policy indicated that "Any employee who witnessed or became aware of alleged , neglect, or , should report such incident to the administrator or supervisor on duty immediately." The policy also indicated that "The administrator or supervisor on duty should notify the resident's legally responsible party and physician and that the notifications should be documented in the resident's progress notes." 3. Review of caregiver B's personnel record revealed a hire date of . Review of Caregiver D's personnel record revealed a hire date of . Review of Caregiver G's personnel record revealed a hire date of . Review of Caregiver H's personnel record revealed a hire date of . None of these personnel records contained documentation to indicate the caregivers received the required 1-hour in-service training within 30 days of	A 077		

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employment that covered resident rights in an assisted living facility and, with the use of the facility's [redacted] prevention policies and procedures, training on recognizing and reporting resident [redacted], neglect, and [redacted]. The findings were discussed with the Regional Director of Health and Wellness on [redacted] at 4 PM, and an opportunity was given to provide additional documentation. At 5 PM, the regional director of health and wellness said the facility did not have documented evidence to indicate caregivers B, D, G, and H received the required training.

Staff A's personnel record revealed a hire date of [redacted]. There was a 2-hour training certificate totally for all the following: facility's philosophy of care, licensure and services provided, tour of community/emergency procedures, adverse reporting, abused neglect [redacted], control/universal precautions, resident rights, confidentiality and family interaction expectations, elopement and [redacted]. This 2-hour training certificate cannot be recognized as the [redacted], neglect, and [redacted] training is required one hour training, as well as the other trainings listed requires 1 hour of completion. There was no other documented evidence to qualify that all required in-service trainings were completed in the file.

Staff C's personnel record review revealed a hire date of [redacted]. The only training completed in the file was the medication assistance with self-administration of medications for 6 hours dated [redacted], and a copy of the certified nursing assistant license which expires [redacted]. There were no required In-service training certificates completed in the file for 1 hour neglect [redacted] training, 2 hours

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A 077	Continued From page 53 pre-service orientation training covering facility type, resident rights and care offered by the facility. This is to be completed before interacting with the residents. Nurse E's personnel record review revealed hire date a . . . . . . The . . . . . , neglect, and , . training certificate were missing. There was no documented evidence that this training was completed. The facility's Resident Policy, dated . . . . . , indicated that as part of its response to allegations of , the facility would report the allegations to the state appropriate Agency and/or state specific hotline and follow the state specific protocol as defined in the regulations. Review of investigation notes, authored by the Human Resource Consultant, dated , revealed that Caregiver G alleged . . . . . misconduct between Staff A and resident #4 sometime in . . . . . . Review of an email correspondence, authored by previous administrator J and dated , revealed that at that point in the investigation, administration believed that Caregiver G's . . . . . , was very accurate, credible and she seemed to be genuine in her concern for resident #4. Staff A seemed to have conflicting . . . . . , but did have some credible excuses. Review of a document, authored by previous administrator J, dated . . . . . , revealed that at the conclusion of the investigation, the facility determined that there was insufficient evidence to support the allegation and an expectation was set forth that Staff A would refrain from any and all interactions with resident #4 only while she was in	A 077		

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A 077	Continued From page 54 her room. 4. On at 10:42 AM, the Regional Director of Operations said she did not know if DCF, the resident's responsible party and the resident's health care provider were notified of the investigation that took place involving staff A and resident #4. On at 12:04 PM, the Director of Health and Wellness said she was familiar with the incident and subsequent investigation involving resident #4 and Staff A. She said DCF and both the resident's responsible party and health care provider were notified and that she would provide documentation of the notifications. At 3:29 PM, she said she could not locate any documentation of notification to DCF, responsible party and a health care provider regarding the investigation involving resident #4. On at 1:30 PM, the Regional Director of Operations, Director of Nursing, Regional Director Health Wellness and Business Office Manager were all in attendance during the exit interview. They all agreed to the findings and did not have any additional questions. Class I	A 077		
A 081 SS=G	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in	A 081		

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A 081	Continued From page 55 duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility.	A 081		

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A 081	Continued From page 56 (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in . . . . control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its . . . . control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , . , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident . . . . , neglect, and , . The facility must use its . . . . prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095,	A 081		

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A 081	Continued From page 57 F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interviews, the facility failed to ensure 7 of 13 sampled staff received a minimum of 1-hour in-service training within 30 days of employment that covered resident rights in an assisted living facility and, with the use of the facility's . . . . . prevention policies and procedures, training on recognizing and reporting resident . . . . . , neglect, and , (A, B, C, D, E, G & H). Findings: The facility's , Neglect, and ,	A 081		

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A 081	Continued From page 58 policy, dated , indicated that education and training of staff relative to the policy on , neglect and mistreatment of residents would be conducted during orientation and annually thereafter, or more often as the need arose. Review of Caregiver B's personnel record revealed a hire date of . Review of Caregiver D's personnel record revealed a hire date of . Review of Caregiver G's personnel record revealed a hire date of . Review of Caregiver H's personnel record revealed a hire date of . None of the personnel records contained documentation to indicate the caregivers received the required 1-hour in-service training within 30 days of employment that covered resident rights in an assisted living facility and, with the use of the facility's prevention policies and procedures, training on recognizing and reporting resident , neglect, and , . The findings were discussed with the Regional Director of Health and Wellness on at 4 PM and an opportunity was given to provide additional documentation. At 5 PM, the Regional Director of Health and Wellness said the facility did not have documented evidence to indicate caregivers B, D, G, & H received the required training. Staff A's personnel record review revealed a hire date of . There was a 2-hour training certificate totally for all of the following: facility's philosophy of care, licensure and services provided, tour of community/emergency procedures, adverse reporting, abused neglect , , control/universal precautions, resident rights, confidentiality and	A 081		

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A 081	Continued From page 59 family interaction expectations, elopement and . This 2-hour training certificate cannot be recognized as the , neglect, and , training is required one hour training, as well as the other trainings listed requires 1 hour of completion. There was no other documented evidence to qualify that all required in-service trainings were completed in the file. Photographic evidence was obtained. Staff C's personnel record revealed a hire date of . The only training completed in the file was the medication assistance with self-administration of medications for 6 hours dated and a copy of the certified nursing assistant license, which expires . There were no required in-service training certificates completed in the file for 1 hour neglect , training, 2 hours pre-service orientation training covering facility type, resident rights and care offered by the facility because he was hired after and this is to be completed before interacting with the residents. Photographic evidence was obtained. Nurse E's personnel record revealed hire date . The , neglect, and , training certificate were missing. There was no documented evidence that this training was completed. On at 8:30 AM, an interview with both Regional Director Health Wellness and the Regional Director of Operations confirmed the findings. Class II	A 081		

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A 165	Continued From page 60	A 165		
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. (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	A 165		

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A 165	Continued From page 61	A 165		

incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident.
(4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident.
(6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415.
(7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The 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

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A 165	Continued From page 62 licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify Department of Children and Families (DCF) when there was an allegation of . . . misconduct involving 1 of 13 sampled staff (A) and 1 of 4 sampled residents (#4). Findings: The facility's Resident Policy, dated . . . . . , indicated that as part of its response to allegations of , the facility would report the allegations to the state appropriate Agency and/or state specific hotline and follow the state specific protocol as defined in the regulations. Review of investigation notes, authored by the Human Resource Consultant, dated . . . . . , revealed that Caregiver G alleged misconduct between staff A and resident #4 during . Review of an email correspondence, authored by previous administrator J and dated , revealed that at that point in the investigation,	A 165		

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A 165	Continued From page 63	A 165		

administration believed that Caregiver G's , was very accurate, credible and she seemed to be genuine in her concern for resident #4. Staff A seemed to have conflicting , but did have some credible excuses.

Review of a document, authored by previous administrator J, dated , revealed that at the conclusion of the investigation, the facility determined that there was insufficient evidence to support the allegation and an expectation was set forth that Staff A would refrain from any and all interactions with resident #4 only while she was in her room.

On at 10:42 AM, the Regional Director of Operations said she did not know if DCF, the resident's responsible party and the resident's health care provider were notified of the investigation that took place involving Staff A and resident #4.

On at 12:04 PM, Director of Health and Wellness said that she was familiar with the incident and subsequent investigation involving resident #4 and Staff A. She said DCF and both the resident's responsible party and health care provider were notified and that she would provide documentation of the notifications. At 3:29 PM, she said she could not locate any documentation of notification to DCF, responsible party and a health care provider in regard to the investigation involving resident #4.

On at 10:05 AM via telephone, the DCF investigator stated she had concerns about an older female with , resident #3, consenting to a encounter with a younger employee, Staff A. The investigator stated the DCF case was pending

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A 165	Continued From page 64 based once receipt of the official Police report. She was informed that during AHCA's investigation, it was discovered that another female victim had a encounter with Staff A in and reported by Caregiver G in . The facility never called DCF and reported the encounter as required. Class III	A 165		