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
	AL11969101	A. BUILDING: _____ B. WING _____	12/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GULL POINT AT ESTERO	22900 LYDEN DR ESTERO, FL 33928

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the [illegible] are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [illegible] submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; ; 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 record review, and interview, the facility failed to maintain the employment status of all employees within the Agency's Background Screening Clearinghouse and report any changes of status within 10 business days for 2 (Staff B, and C) of 4 employees reviewed for the Background Screening Clearinghouse.	CZ814		

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CZ814	Continued From page 1 The findings included: Review of Staff B's file revealed a hire date of [redacted] as a caregiver/Med Tech. Review of the Agency' Clearinghouse employee roster revealed Staff B was added on the Clearinghouse roster on , 23 days after hire. Review of Staff C's file revealed a hire date of [redacted] as the Wellness Director. Review of the Agency' Clearinghouse employee roster revealed Staff B was not added on the Clearinghouse roster for the facility. On at 10:30 a.m., during an interview, the Business Office manager confirmed Staff C was not added to the Agency's background screening roster and Staff B was added past the 10 days as required. Unclassified .	CZ814		
CZ830	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the	CZ830		

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CZ830	Continued From page 2 agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon	CZ830		

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CZ830	Continued From page 3 demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to submit annually and maintain documentation of a current Comprehensive Emergency Management Plan (CEMP), approved by the local emergency management agency to ensure the safety and welfare of all residents. The findings included:	CZ830		

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CZ830	Continued From page 4 On at 9:45 a.m., observation of Emergency Power Plan approval letter posted on facility wall in front lobby indicated the Emergency Power Plan (EPP) was approved through . The letter further indicated going forward the Emergency Power Plan must be included in the facility's annual Comprehensive Emergency Management Plan (CEMP) submission as an annex/addendum. On at 9:50 a.m., request was made to the Executive Director for documentation of the facility CEMP/EPP with approval letter. On at 12:35 p.m., during an interview, the Executive Director stated, "the facility CEMP/EPP was not approved for last year, it was submitted and rejected and was never resubmitted. On ..... the Administrator provided a Comprehensive Emergency Management Plan (CEMP) letter dated 12//20/2021 that indicated the facility's CEMP did not currently meet the Emergency Management criteria requirements set forth by the Agency for Healthcare of Administration. The letter also indicated for the facility to resubmit the entire correct plan within 30 days. On ..... at 1:59 p.m., during an interview, the Executive Director confirmed the facility does not have a current approved CEMP/EPP and has not submitted the plan for the year. Class III	CZ830		

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A 000	Initial Comments An unannounced relicensure, limited nursing services, emergency power plan monitoring and complaint survey #2022003926 and #2022009558 was conducted on [redacted] though [redacted] at Gull Point at Estero, an assisted living facility in Estero, Florida. Complaint #2022003926 was unsubstanitated. Complaint #2022009558 was substantiated. The following is a description of the deficiencies.	A 000		
A 052	429.256([redacted]); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an [redacted] syringe that is prefilled with the proper dosage by a pharmacist and an [redacted] that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the	A 052		

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A 052	Continued From page 1 resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the	A 052		

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A 052	Continued From page 2 resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be [illegible] or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take	A 052		

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A 052	Continued From page 3 the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by:	A 052		

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A 052	Continued From page 4 Based on observation, and interview, the facility failed to ensure staff who assist residents with self-administration of medications do so in accordance with proper procedure for 4 (Residents # 3, # 10, # 11, # 12) of 4 medications observations. The findings included: Review of the policy Medication Management, Assisting with oral Medication revealed Standard: Residents will receive assistance with oral medications using acceptable standards of practice. Tablets and Capsules: When assisting with tablets or capsules, try not to touch the medication with your . . . What to do with tablets or capsule: 3. Wash your . . .- be sure to wash your . . . prior to med pass. On at 8:51 a.m., Staff E (med tech) was observed assisting Resident #3 with medications. Staff E parked the medication cart in the Veterans room (television room) where residents were seated. Staff E took Resident #3's medication from the medication cart, placing the dosage of the medications into a container touching the medications with her bare . . . Staff E took the cup with the medications over to Resident #3 seated in a corner of the room and said to Resident #3, "I have your pills," giving Resident #3 the medications without informing the resident what medications she was being assisted with and without taking the medications in their properly labeled container to read to the resident. While taking the medications, 1 pill . into the cup of water Resident #3 was drinking, Staff E took the cup and with a spoon retrieved the pill form the cup and spoon fed the medication into	A 052		

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A 052	Continued From page 5 Resident #3's . . . . . Staff E continued to the next med pass and no hygiene was performed. On . . . . . at 8:59 a.m., Staff E was observed assisting Resident #10 with medications, no hygiene was performed prior to starting the med pass and after previous med pass. Staff E took Resident #10's medication from the medication cart, placing the dosage of the medications into a container touching the medications with her bare . Staff E took the cup with the medications over to Resident #10 seated in a corner of the room and said to Resident #10, "[resident name] it's your meds, your 8 am meds." Resident #10 asked, "What are they for?" Staff E replied, "It's for the ," giving Resident # 10 the medications without informing the resident what medications she was being assisted with and without taking the medications in their properly labeled container to read to the resident. Staff E continued to the next med pass and no hygiene was performed. On . . . . . at 9:07 a.m., Staff E was observed assisting Resident #11 with medications, no hygiene was performed prior to starting the med pass and after previous med pass. Staff E took Resident #11's medication from the medication cart, placing the dosage of the medications into a container, touching the medications with her bare . Staff E took the cup with the medications over to Resident #11 seated in a corner of the room and said to Resident #11, "[resident name], I got your medicine, its just 1 pill." Staff E gave Resident #11 the medications without informing the resident what medications she was being assisted with and without taking the medications in their properly labeled container to read to the resident. Staff E continued to the next med pass	A 052		

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A 052	Continued From page 6 and no hygiene was performed. On at 9:15 a.m., Staff E was observed assisting Resident #12 with medications, no hygiene was performed prior to starting the med pass and after previous med pass. Staff E took Resident #12's medication from the medication cart, placing the dosage of the medications into a container touching the medications with her bare . Staff E took the cup with the medications poured the medications into a package and paced the package in the pill crush machine, crushing the bag of medications, Staff E poured the crushed medications into a souffle cup, adding a spoonful of applesauce to the medications in the cup. Staff E took the cup with the medication over to Resident #12 seated in a corner of the room and said to Resident #12, "[resident name], I have your meds," giving Resident #12 the medications without informing the resident what medications she was being assisted with and without taking the medications in their properly labeled container to read to the resident. Staff E continued to the next med pass and no hygiene was performed. On at 9:20 a.m., during an interview, Staff E stated "I only tells the resident what medications they are being assisted with if they ask." Staff E acknowledged she did not tell the resident what medications she was assisting them with and did not perform proper hygiene while assisting with the med pass. On at 9:55 a.m., during an interview, the Executive Director said the Med techs when assisting with self-administration of medications are required to read the medications to the residents. Executive Director confirmed that Staff E did not follow the proper procedures when	A 052		

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A 052	Continued From page 7 assisting Resident #3, # 10, #11, and # 12 with self-administration of medications. Class III .	A 052		
A 078	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of . . . . . testing materials satisfies the annual . . . . examination requirement. An individual with a positive . . . . . test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable	A 078		

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A 078	Continued From page 8 (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility [redacted] to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure that within 30 days of employment staff submit a written statement from a health care provider documenting the individual is free from signs/symptoms of communicable and evidence of freedom from	A 078		

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	AL11969101	A. BUILDING: _____ B. WING _____	12/07/2022

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A 078	Continued From page 9 . . . . . ( ) documented annually thereafter for 3 (Staff B, C, D) of 4 employee records reviewed. The findings included: On . . . a review of Staff B's employee file revealed a hire date of as a caregiver/Med Tech. Staff B's file contained no evidence of documentation of a statement from a health care provider that indicated Staff B was free from signs or symptoms of communicable . . . . . including . . On . . . . review of Staff C's employee file revealed a hire date of as the Wellness Director. Staff C's file contained no evidence of documentation of a statement from a health care provider that indicated Staff C was free from signs or symptoms of communicable including . . On . . . . a review of Staff D's employee file revealed a hire date of as a Med tech. Staff D's file contained evidence of documentation of , completed on . . . . and electronically signed by the healthcare provider which indicated no radiographic evidence for active . There was no further evidence of freedom form communicable . . . . . including . . annually thereafter. On at 10:30 a.m., during an interview, the Business office Manger confirmed there was no evidence of documentation of a communicable . . . . . statement signed by a healthcare provider indicating Staff B, and C were free from signs and symptoms of communicable	A 078		

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A 078	Continued From page 10 On ... ... at 10:54 a.m., the Executive Director confirmed there was no evidence of freedom from . annually for Staff D. Class III .	A 078		
A 081	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. 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	A 081		

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A 081	Continued From page 11 living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in [illegible] control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its [illegible] control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to [illegible] borne [illegible], may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents.	A 081		

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A 081	Continued From page 12 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, 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.	A 081		

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A 081	Continued From page 13 This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure facility employees completed a 2 hour pre-service orientation prior to interacting with residents, 3 hours of in-service training for Activities of Daily Living and Behavioral needs, and 1 hour of in-service training for Nutritional Safe Food Handling, Control, Reporting Major Incidents, Reporting Adverse Incidents and Facility Emergency Procedures, Resident Rights, Recognizing/Reporting /Neglect, Incident Reporting training and Elopement Response Training, as required by Florida Administrative Code within 30 days of employment for 3 (Staff B, C, D) of 4 employee files reviewed. The findings included: On , record review of Staff B caregiver/Med tech, and Staff C Wellness Director, and Staff D Med tech, revealed the following: Staff B's file revealed a hire date of as a caregiver/Med tech. Staff B's file contained no documentation of completing a 2 hour pre-service orientation prior to interacting with residents, 3 hours of in-service training for Activities of Daily Living and Behavioral needs, 1 hour of in-service training for Nutritional Safe Food Handling, Control, Reporting Major Incidents, Reporting Adverse Incidents and Facility Emergency Procedures, Resident Rights, Recognizing/Reporting /Neglect, Incident Reporting training and Elopement Response within 30 days of employment as required.	A 081		

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A 081	Continued From page 14 Staff C's file revealed a hired date of [illegible] as the Wellness Director. Staff C's file contained no evidence of documentation of completing 2-hour pre-service orientation prior to interacting with residents. Staff D's employee file revealed a hire date of [illegible] as a Med Tech. Staff D's file contained a certificate for in-service training for 2 hours of pre-service orientation dated [illegible]. There was no signature/credentials for the Administrator or the instructor of the training and no signature of the employee. On [illegible] at 12:18 a.m., during an interview, the Business Office Manager confirmed Staff B, and C, did not have all the required in-services within 30 days of their employment and prior to interacting with the facility resident. On [illegible] at 10:54 a.m., during an interview, the Executive Director reviewed the file for Staff D and confirmed the certificate in the file does not meet the requirements as it did not contain the signature/credentials of the Administrator who provided the training and the employee. Class III .	A 081		
A 082	59A-36.011(4) FAC Training - / (4) [illegible] (/). Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must	A 082		

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A 082	Continued From page 15 complete a one-time education course on and , including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure facility employees complete a one-time education course on and (/) within 30 days of employment for 1 (Staff B) of 4 employee files reviewed for / training. The findings included: On record review of Staff B's employee file revealed a hire date of as a caregiver/Med tech. Staff B's file contained no evidence of training being completed within 30 days of employment for / . On at 10:30 a.m., during an interview, the Business Office Manager acknowledged Staff B's file contained no documentation of the training being completed. Class III .	A 082		
A 090	59A-36.011(11) FAC Training - (11) TRAINING. (a) Currently employed facility administrators,	A 090		

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A 090	Continued From page 16 managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding . (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure facility employees complete at least one hour of in-service training in the facility's policies and procedures regarding ( ) within 30 days after employment and maintain documentation of completion for 1 (Staff B) of 4 employee files reviewed. The findings included: On , record review of Staff B's employee file revealed a hire date of as a Caregiver/Med tech. Staff B's file contained no documentation of having completed an in-service on within 30 days of hire. On at 10:30 a.m., during an interview, the Business Office Manger acknowledged the findings of the missing in-service training required for . Class III .	A 090		

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A 161	Continued From page 17	A 161		
A 161	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . . . . . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in section 429.174, F.S., and rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and	A 161		

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A 161	Continued From page 18 administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity [redacted] to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure personnel records for staff contain documentation required for compliance with Florida Administrative Code for job description for 3 (Staff B, C, D) of 4 employee files reviewed. The findings included: Record review of Employee file for staff B revealed a hire date of [redacted] as a caregiver/Med Tech. Staff B's employee file failed to contain evidence of documentation of an application with references and a job description as required. Record review of Employee file for staff C revealed a hire date of [redacted] as the Wellness Director. Staff C's employee file failed to contain evidence of documentation of an application with references and a job description as required.	A 161		

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A 161	Continued From page 19 Record review of Employee file for staff D revealed a hire date of as a Med Tech. Staff B's employee file failed to contain evidence of documentation of a job description as required. On at 10:30 a.m., the Business Office Manager confirmed the missing documentation from the employee files for staff B, C and D. Class III	A 161		
A 165	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;	A 165		

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A 165	Continued From page 20 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse 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	A 165		

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A 165	Continued From page 21 who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review, and staff interview, the facility failed to report within 1 business day after the occurrence of an adverse incident, a preliminary report and provide within 15 days a full report including investigation of the incident to the Agency for Healthcare Administration (AHCA) for 4 (Residents# 2, #16, # 17 and #18) of 6 residents surveyed for . . with injury and transfer to more acute care. The findings included:	A 165		

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A 165	Continued From page 22 Review of facility incident log on revealed resident # 2 was found on the floor in her room on . 911 was called and resident # 2 was transported to the hospital via ambulance for further evaluation. Agency for Healthcare Administration (AHCA) Day 1 preliminary report was filed on indicated resident # 2 was diagnosed with a . Further review of adverse incidents showed no day 15 with full investigation had been filed with AHCA for this incident. On at 1:04 p.m., the Executive Director reviewed the documentation provided and said, "that's Odd, because it should have been done, the day 15 adverse report should have been completed and submitted after the facility did a full investigation on the ," she confirmed no day 15 adverse incident had been filed for the incident with resident # 2. Review of facility incident log incident on revealed Resident #16 was found on the floor beside her bed on her with noted from the left side of her on was also noted. 911 was called and Resident #16 was transported to the hospital via ambulance for further assessment. A review of adverse incidents showed none had been filed with AHCA for this incident. Review of facility incident log incident on revealed Resident #16 was outside in courtyard at an activity and hitting her on the ground on also noted. 911 was called and Resident #16 was transported to the hospital via ambulance for further assessment.	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969101	A. BUILDING: _____ B. WING _____	12/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GULL POINT AT ESTERO	22900 LYDEN DR ESTERO, FL 33928

(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 165	Continued From page 23 A review of adverse incidents showed none had been filed with AHCA for this incident. On Review of the facility incident log revealed resident # 17 was found with to the of his on . 911 was called and resident # 17 was transported to the hospital via ambulance for further assessment. A review of adverse incident showed none had been filed with AHCA for this incident, and no documentation of an investigation was completed by facility staff and management. On Review of the facility incident log revealed resident # 18 was found on floor outside of her room door, complaining of right , on . 911 was called and resident # 18 was transported to the hospital via ambulance for further assessment A review of adverse incident showed none had been filed with AHCA for this incident. On at 10:03 a.m., the Executive Director said if a resident goes to the hospital and return the same day, they don't complete an adverse incident as the resident is being evaluated, she states the previous administrator had told her that she would only file adverse incidents for , broken bones, , so she only files adverse incidents when she is informed of a when they go to the hospital. Executive Director confirmed no documentation of an investigation for the incident with resident # 17. She confirmed no adverse incidents filed for the residents after and transferred to hospital. Class III	A 165		

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
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