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
	AL11910842	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS OF CLEARWATER, THE	420 BAY AVENUE CLEARWATER, FL 33756

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation (complaint number: 2022018963) was conducted at Oaks of Clearwater (The) on . Deficiencies were identified at the time of survey.	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	A 008		

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A 008	Continued From page 1	A 008		

be made 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

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A 008	Continued From page 2 administrator meet his or her responsibilities under subsection (1). Further, 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 , , 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 , , 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 , , , or any other	A 008		

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A 008	Continued From page 3	A 008		

communicable , which are likely to be transmitted to other residents or staff,
7. A statement on the day of the examination that, 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

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A 008	Continued From page 4 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). (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 record review and interview, the facility failed to obtain a -to- health assessment	A 008		

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A 008	Continued From page 5 with all required data for one Resident (#2) of one sampled resident. Findings Included: A record review for Resident #2, conducted on , revealed that Resident #2's health assessment form dated did not note the type of assistance that the resident required for toileting. Resident #2 was admitted on . During an interview with the Assisted Living Wellness Director, conducted on at 01:45pm, the Wellness Director agreed that Resident #2's health assessment form did not note the type of assistance that the resident required for toileting. Class III	A 008		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the	A 025		

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A 025	Continued From page 6 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 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	A 025		

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A 025	Continued From page 7 changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide emergency access to one (Resident #1) of eight residents whose door was locked on the memory care unit. Findings Included: A review of emergency medical services ( ) response to an emergency call for Resident #1 on at 06:47pm, conducted on , revealed that responded to Resident #1's room on the 3rd floor memory care unit. found Resident #1's room entry door was locked and were extremely loud in banging on the door and announcing themselves. began walking up and down the hallways and yelling for staff and was unable to locate facility staff to enter Resident #1's room. was unable to exit the locked memory care unit to obtain forcible entry tools due to a code needed for the exit door. There was no staff found on this floor for approximately ten minutes. Once gained access to Resident #1's room, found Resident #1 and displayed signs of lividity and rigor. During an interview with Staff P (Licensed Practical Nurse and Assisted Living Wellness Director), conducted on at 10:24am, Staff P stated that Resident #1 resided in the memory care unit and was admitted to Hospice services. On , Staff H (Resident Care Aid) and Staff G (Resident Care Aide) informed Staff P that Resident #1 was not feeling well. The Hospice	A 025		

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A 025	Continued From page 8 Registered Nurse (RN) was informed and in the building at the time and assessed Resident #1. The Hospice RN contacted the family and got an ordered for Resident #1 as the Hospice RN suspected a , . Between 03:30pm and 03:45pm on , the front desk received a telephone call from Resident #1's family member who requested staff to check on the resident. Staff Q (Licensed Practical Nurse and Memory Care Wellness Director) went to check on the resident and there was no change in his condition. At 06:05pm on , Staff P received a missed telephone call and voicemail from Staff A (Resident Care Aid) that Resident #1 had , , . Staff P telephoned Staff A immediately and instructed the staff to inform both Staff Q and Hospice. Staff P stated that one of the personnel was questioning lividity with Resident #1. During an interview with Staff Q, conducted on at 10:31am, Staff Q stated that Staff G notified her that Resident #1 didn't look very well on between 12:00pm and 01:00pm. Staff Q stated that when Resident #1's family member telephone the front desk, Staff Q went to check on the resident at 04:00pm and he was still breathing. Staff Q notified the Hospice RN. The Hospice RN was in the building and went to check on the resident. Staff Q stated that she had a telephone conversation with an unidentified staff on between 07:20pm and 07:40pm and was yelling into the telephone and saying that Resident #1 had been for about six hours due to the lividity and rigor. During an interview with the Administrator, conducted on at 10:32am, the	A 025		

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A 025	Continued From page 9 Administrator stated that Resident #1's family member telephoned -1 emergency personnel and the facility was not aware that was in route to the facility. The Administrator stated when facility staff telephone -1 in the event of an emergency, one elevator was reserved for personnel. During an interview with Staff A (Resident Care Aide), conducted on at 11:07am, Staff A stated that she was not working on the 3rd floor memory care and just went to assist to get into Resident #1's locked room. Staff A stated that other staff (not identified) reported that Resident #1 was declining and did not eat dinner and that Staff Q checked on the resident around 04:00pm on . Staff stated that the resident aides checked on Resident #1 around 05:00pm on . Staff A stated that arrived at the facility at 07:00pm on and pronounced Resident #1 at 07:14pm on . Staff A stated that she unlocked Resident #1's door to allow to enter and then assisted with gathering the resident's information. Staff A stated that there were three employees on the 3rd floor, and she went to her assigned floor. During an interview with Resident #1's family member, conducted on at 11:47am, the family member stated that Resident #1 , on . The family member stated that Resident #1 had hospice , care and that he was not receiving , care. The family member stated that she had telephoned hospice and the facility because she wanted Resident #1 to have a , to check for	A 025		

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A 025	Continued From page 10	A 025		

possible , and never received an answer from the facility. The family member stated that hospice wanted to take him to their in-patient hospice house only after four telephone calls later. The family member stated that she telephoned Resident #1's primary care physician and got an ordered for the resident and not the facility or hospice. The family member stated that she made it clear that she wanted for Resident #1 to go to the hospital, and she agreed to revoke hospice services. The family member stated that she telephoned -1 and headed to the facility. The family member stated that preceded her and when she arrived, Resident #1's room door was locked. The family member stated that the facility always locked the resident in his room. The family member stated that because the door was locked, was unable to get to the resident. The family member stated that herself and began running around yelling for staff. The family member stated that she called the front desk and informed the unidentified staff that were at the facility and were unable to get in Resident #1's locked room. The family member stated that Staff A came up to the 3rd floor and unlocked Resident #1's door. Upon entry, Resident #1 was found by . The family member stated that there was no staff on the 3rd floor with about twenty-five patients and " said he was for about four to six hours". The family member stated that the employees don't always know what's going on and that Resident #1 had two bad in and was supposed to have a wheelchair that hospice delivered in . The family member stated that Resident #1 still did not have the wheelchair and that the facility did not know where the wheelchair was after repeated inquiries.

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A 025	Continued From page 11 During an interview with Staff I (Resident Care Aide), conducted on at 12:40pm, Staff I stated that resident room doors were usually kept locked because the memory care residents would and got other residents' belongings and their families would get upset. Staff I stated that the employees don't allow residents to stay in their rooms and kept their room doors locked. During a tour of the 3rd floor memory care unit, conducted on at 12:25pm, Residents #2, #4, #6, #7, #8, #9, and #10's room doors were found locked and unable to access the rooms. A review of the resident census, conducted on , revealed that there were sixteen memory care residents that resided on the 3rd floor locked memory care unit and twelve residents that resided on the 4th floor locked memory care unit. A review for the staffing schedule for the week of through , conducted on , revealed on the 03:00pm to 11:00pm shift, there were two staff scheduled for the memory care units (3rd and 4th floors). During an interview with Staff D (an unlicensed Medication Technician), conducted on at 03:01pm, Staff D stated that Resident #1 was a little tired on and the Hospice RN came to assess the resident between 10:30am to 11:00am on . Staff D stated that Resident #1 took his morning medications that morning, but he was too tired to take his afternoon medications.	A 025		

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A 025	Continued From page 12 During an interview on at 03:35pm, Staff A stated that the front desk receptionist had told her that needed her and when Staff A arrived on the 3rd floor, Staff F (Agency Resident Care Aide) was watching the residents and Staff E (Agency Resident Care Aide) was in a resident's room providing care. Staff A stated that some of the residents required two people for assistance. During an interview with Staff F (Agency Resident Care Aide), conducted on at 03:40pm, Staff F stated that he checked on Resident #1 at 03:00pm and at 04:30pm on and the resident was okay. Staff F stated that Staff E checked on Resident #1 at around 06:00pm on and then Staff F and Staff E were taking care of Resident #9 together in Resident #9's room at 06:15pm on and when they came out of that room about 07:00pm was when he spotted law enforcement. Staff F stated that there was usually a Medication Technician on the floor, and he thought she was there. Staff F stated that Resident #9's door was open. Staff F then stated that he was in Resident #2's room and Staff E was in Resident #9's room when Staff E came and got him to help assist Resident #9 with getting ready for bed. Staff F stated that the reason Resident #1's door was locked, was because there was one resident (not identified) that into other resident rooms and takes their belongings. Staff F stated that the employees also lock both hall rooms and the kitchen. Staff F stated that the resident room doors were kept locked even when residents were in bed and that he has found residents sitting in other resident's rooms. Staff F stated that employees kept the	A 025		

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A 025	Continued From page 13	A 025		

resident lady's apartments locked to keep them safe because there was a male (not identified) resident that would roam into their rooms.

During an interview with Staff C, conducted on at 03:50pm, Staff C stated that she was on a ten-minute break and upon her return from break and noticed that they [.] were going to Resident #1's room. Staff C stated that Staff E checked on Resident #1 at 06:00pm and the resident was alive. Staff C stated that she attempted to give Resident #1 medications at 04:00pm and he refused his medications because he wouldn't open his and was sleeping. Staff C stated that she informed Staff D and Staff F that Resident #1 refused his medications. Staff C stated that Staff F informed her that Resident #1 was bringing up yellow on and was up in the dining room. Staff C stated that Staff D and F were in Resident #9's room when she arrived on the floor. Staff C stated that the reason employees kept resident room doors locked was because the residents would go into each other's rooms and the male residents would get in bed with female residents.

During an interview with on-call hospice RN, conducted on at 04:08pm, the on-call RN stated that she arrived at the facility sometime between 08:00pm to 09:00pm on but had pronounced Resident #1's at 07:15pm before her arrival. The on-call RN stated that she spoke to Resident #1's family member in the parking lot. The family told the on-call RN that she did not want hospice involved and had revoked hospice services at 05:00pm on . The family member told the on-call RN that when the family member arrived, all of the resident room

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A 025	Continued From page 14	A 025		

doors were locked and the family member went down the hallways yelling, and someone called 911 and showed up. The family member told the on-call RN that no staff could be found on the 3rd floor memory care unit and the only staff found was the front desk receptionist.

A record review for Resident #1, conducted on , revealed that Resident #1 was admitted on and discharged on due to the resident's . According to Resident 1's health assessment form dated , the resident had diagnoses of without behavioral disturbance, , , , , and a history of mental behavioral disturbances and with restlessness and agitation. Resident #1 was admitted to hospice services on an unknown date as there was no consent form agreeing to hospice services in the resident's record. There was no updated health assessment form upon admission to hospice services. Resident #1's health assessment was not updated upon the decline from the need for a walker to a wheelchair. There was no interdisciplinary care plan or a physician's order to admit to hospice services in Resident #1's record. There was no evidence of increased supervision or interventions for prevention implemented after Resident #1 had two in which the resident sustained a injury with each on and . Resident #1's record noted the resident was observed by staff up and ambulating throughout the memory care unit on and . There was no indication that the resident was using an assistive device while ambulating. On , while speaking with Resident #1's family member via a telephone call,

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A 025	Continued From page 15 Staff Q noted that she advised the family member that the facility could not stop Resident #1 from falling but could put measures in place to reduce . There was no indication in Resident #1's record of those measure that were put in place. Resident #1 received a wheelchair provided by hospice on . The facility misplaced or lost the wheelchair and continued not to have the wheelchair at the time of the two . A record review for Resident #2, conducted on , revealed that Resident #2 was admitted on . According to Resident #2's health assessment form dated , the resident had a diagnosis of 's and with memory loss and , . Resident #2's health assessment was not updated upon the decline from independent ambulation to the need for a wheelchair. Resident #2's Resident Evaluation dated noted that the resident ambulated independently without the use of a walker or wheelchair. There was no other evaluation form in the resident's record. A record review for Resident #3, conducted on , revealed that Resident #3 was admitted on an unknown date as there was no admission date noted in the resident's record. According to Resident #3's undated health assessment form, the resident had a diagnosis of and required precautions for repeated . Resident #3 was admitted to hospice services on . There was no updated health assessment form upon admission to hospice services. Resident #3's health assessment was not updated upon the decline from the need for a four-wheeled walker to a wheelchair. There was no interdisciplinary care	A 025		

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plan or a physician's order to admit to hospice services in Resident #3's record. Resident #3's Pre-admission Healthcare Evaluation dated was incomplete and not signed for approval of admission per the facility policy and procedures. Resident #3's Resident Evaluation and Risk Assessments were blank and not dated.

A review of the facility's Pre-admission Health Care Evaluation undated policy and procedures, conducted on , revealed that each resident was supposed have a pre-admission health evaluation prior to admission.

A review of the facility's Resident Evaluation undated policy and procedures, conducted on , revealed that each resident was supposed to have the evaluation upon admission, quarterly, and with changes in conditions.

A review of the Risk Assessment undated policy and procedures, conducted on , revealed that each resident was supposed to have a assessment completed upon the start of care and re-certification.

During an attempt to review the facility's policy and procedures for the locking of resident rooms, conducted on at 01:30pm, there was no policy and procedures for the locking of resident rooms provided.

During an interview with Staff Q, conducted on at 12:50pm, Staff Q stated that Staff C, Staff E, and Staff F were on duty on the 3rd floor on when arrived at 06:50pm. Staff Q stated that hospice delivered a wheelchair

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A 025	Continued From page 17 for Resident #1 to use on but the resident never received the wheelchair. Staff Q stated that both care staff were in resident rooms doing changes for the evening care for bed rounds when showed up. Staff Q stated that there was no policy and procedures for the locking of resident rooms. During an interview with the Administrator, conducted on at 01:30pm, the Administrator stated that there was a policy and procedures for the locking of resident rooms, but the Administrator did not provide the document. During an interview with Staff P, conducted on at 01:45pm, Staff P agreed that Resident #2's record did not contain evidence that the resident had decline from independent ambulation to the use of a wheelchair. Staff P agreed that Resident #3's record did not contain evidence that the resident had declined from ambulation with a four-wheeled walker to the use of a wheelchair. Staff P agreed that the facility did not follow their policy and procedures for assessments for Pre-admission Healthcare Evaluation, Resident Evaluation, and Risk Assessments for Residents #2 and #3. Staff P agreed that Residents #2 and #3 did not have an updated health assessment form consistent with the resident's current level of care need. Staff P agreed that Resident #3's record did not contain the required documents for continued residency under hospice service such as a physician's order for the resident to be admitted to hospice services or interdisciplinary care plan. Class III	A 025		

Agency for Health Care Administration

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A 030	Continued From page 18	A 030		
A 030 SS=G	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; . . . . , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida . . . Hotline, 1(800)96- . . . or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to	A 030		

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A 030	Continued From page 19 Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside.	A 030		

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A 030	Continued From page 20 429.28 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 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.	A 030		

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A 030	Continued From page 21 (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 representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program	A 030		

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A 030	Continued From page 22 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 retaliatory action cannot be taken against a	A 030		

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A 030	Continued From page 23 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 observation, record review, and interview, the facility failed to honor resident rights specifically by depriving residents free access to their rooms and belongings by keeping eight Residents (#1, #2, #4, #6, #7, #8, #9, and #10) of eight sample resident room door locked. Furthermore, the facility failed to honor the rights of Resident (#1) by locking the resident in his room and inaccessible to emergency personnel.	A 030		

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A 030	Continued From page 24 By keeping resident rooms locked, placed all memory care residents at risk of physical or emotional harm and/or injury. Findings Included: A review of emergency medical services ( ) response to an emergency -1 telephone call for Resident #1 on at 06:47pm, conducted on , were unable to access Resident #1 due to his room door was locked and there was no staff present to assist on the 3rd floor memory care unit for approximately ten minutes and found Resident #1 upon entry into the room. pronounced Resident #1's time of at 07:14pm. During an interview with Resident #1's family member, conducted on at 11:47am, the family member stated that she telephoned -1 because she wanted Resident #1 to go to the hospital for evaluation and treatment. The family member stated that upon arrival, there was no staff on the 3rd floor and the resident's room door was locked and was unable to access the resident. Upon access of the room, found Resident #1 . The family member stated that the facility always locked the resident in his room. During an interview with Staff I (Resident Care Aide), conducted on at 12:40pm, Staff I stated that resident room doors were usually kept locked because the memory care residents would and got other residents' belongings and their families would get upset. Staff I stated that the employees don't allow residents to stay in their rooms and kept their room doors locked.	A 030		

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A 030	Continued From page 25 During a tour of the 3rd floor memory care unit, conducted on at 12:25pm, Residents #2, #4, #6, #7, #8, #9, and #10's room doors were found locked and unable to access the rooms. During an interview with Staff A (Resident Care Aide), conducted on at 03:35pm, Staff A stated that the employees kept resident doors locked in the memory care unit to keep residents from roaming into other resident rooms while staff put everyone to bed. During an interview with Staff F (Agency Resident Care Aide), conducted on at 03:40pm, Staff F stated that the reason Resident #1's door was locked, was because there was one resident (not identified) that into other resident rooms and takes their belongings. Staff F stated that the employees also lock both hall rooms and the kitchen. Staff F stated that the resident room doors were kept locked even when residents were in bed and that he has found residents sitting in other resident's rooms. Staff F stated that employees kept the resident lady's apartments locked to keep them safe because there was a male (not identified) resident that would roam into their rooms. During an interview with Staff C, conducted on at 03:50pm, Staff C stated that the reason employees kept resident room doors locked was because the residents would go into each other's rooms and the male residents would get in bed with female residents. During an interview with on-call hospice RN, conducted on at 04:08pm, the on-call	A 030		

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A 030	Continued From page 26 RN was told by Resident #1's family member that Resident #1's door was locked and was unable to access the resident and that all resident room doors were locked and that there was no staff on the 3rd floor. During an attempt to review the facility's policy and procedures for the locking of resident rooms, conducted on at 01:30pm, there was no policy and procedures for the locking of resident rooms provided. During an interview with Staff Q, conducted on at 12:50pm, Staff Q stated that there was no policy and procedures for the locking of resident rooms. During an interview with the Administrator, conducted on at 01:30pm, the Administrator stated that there was a policy and procedures for the locking of resident rooms, but the Administrator did not provide the document. Class II	A 030		
A 034 SS=D	59A-36.007(9) ASSISTIVE DEVICES (9) ASSISTIVE DEVICES. Facilities are responsible for ensuring the safe usage of a resident's assistive devices. (a) The facility must have policies and procedures that include the requirements and methods for assessing the physical condition of assistive devices that may injure the resident and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device.	A 034		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 034	Continued From page 27 (b) Documentation of each assistive device a resident uses must be included in the resident's record. (c) Direct care staff using assistive devices while rendering personal services to residents must know how to operate and utilize the equipment. (d) All assistive devices must be clean, in good repair, and free of hazards. (e) The facility must encourage and allow the resident to function with independence when using the assistive device. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to have policies and procedures to ensure the safe usage and condition of assistive devices. Additionally, the facility failed to have policies and procedures for the recommendation of repair and replacement of assistive devices. Furthermore, the facility failed to have procedures in place to assess the physical condition and cleanliness of the assistive devices and failed to have the assistive devices documented in resident records for one former resident (#1) and two current residents (#2 and #3) of three sampled residents that used assistive devices of a wheeled walker or wheelchair. Findings Included: During an interview with Resident #1's hospice Registered Nuresdientse (RN), conducted on at 11:15am, the RN stated that hospice delivered a wheelchair for Resident #1 on and Resident #1 never received that wheelchair. During an interview with Resident #1's family	A 034		

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	AL11910842	A. BUILDING: _____ B. WING _____	12/29/2022

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A 034	Continued From page 28 member, conducted on at 11:47am, the family member stated that Resident #1 had a wheelchair delivered by hospice in and the resident never received that wheelchair. The family member stated that Resident #1 was supposed to have been using the wheelchair and by the resident had two bad and continued not to have a wheelchair. When Resident #1 had the bad , the family member inquired as to the reason that the resident was not using his wheelchair and the facility did not know where the wheelchair was. During an observation of Resident #1's wheelchair and walker, conducted on at 12:50pm, Resident #1's walker and wheelchair were found in the resident's former room. The walker was covered in dust and grime to the seat, push handle, frame, and wheels. The wheelchair was covered in dust, grime, food residue, and crumbs to the entirety of the chair which included the seat, backrest, push handles, wheels, frame, and armrest. The material was fraying to the edge of the seat. Resident #2 and #3's wheelchairesdients were observed while the residents were seated in the wheelchairesdients eating lunch in the dining room. Resident #2's wheelchair was covered in dust, grime, food residue, and crumbs to the entirety of the chair which included the seat, backrest, push handles, wheels, frame, and armrest. There were hair strands twisted in the wheels. Resident #3's wheelchair was covered in dust, grime, food residue, and crumbs to the entirety of the chair which included the seat, rest, push handles, wheels, frame, and armrest. There were no names and room numberesdients on Resident #1, #2, and #3's assistive devices.	A 034		

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A 034	Continued From page 29 A record review for Resident #1, conducted on , revealed that Resident #1 was admitted on and discharged on due to the resident's . Resident #1's heath assessment form dated noted that the resident required the use of a walker. There was no evidence in Resident #1's record that the resident used a wheelchair. Resident #1 had a on at 03:43pm and sustained a injury. It was noted that on and , the resident was up ambulating. There were no notations regarding the use of an assistive device of a wheelchair or walker. On at 05:51pm, Resident #1 had another with injury. On , it was noted that Resident #1's family member contacted the facility regarding the whereabouts of the resident's wheelchair that was delivered in by hospice. Staff K signed for the wheelchair in , and it was observed "in the lobby for a long time". A search of the facility for the wheelchair took place and the wheelchair was not located. The facility offered for Resident #1's family member to come to the facility and pick out one of a few new wheelchairesdients that were found that did not belong to any other resident for Resident #1 to use. There was no evidence in Residents #1, #2, or #3 were instructed or assessed for the safe use of the wheelchairesdients. There was no evidence that the residents' assistive devices were cleaned, or the physical condition was inspected on a regular basis. A record review for Residents #2, conducted on , revealed that Resident #2's records did not contain any evidence that the resident required the use of a wheelchair assistive device.	A 034		

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A 034	Continued From page 30 Resident #2 was admitted on . Resident #2's health assessment form dated did not note that the resident required the use of an assistive device of a wheelchair and did not note any physical or sensory limitations. Resident #2's Resident Evaluation form dated noted that the resident ambulated without the use of a walker or wheelchair. There was no other Resident Evaluation noted in the resident's record. A record review for Residents #3, conducted on , revealed that Resident #3's records did not contain any evidence that the resident required the use of a wheelchair assistive device. Resident #3 was admitted on an unknown date as the date of admission was not noted in the resident's record. Resident #3's undated health assessment form noted that the resident required the use of a four wheeled walker and made no notation regarding the use of a wheelchair. Resident #3's undated Resident Evaluation form was blank and did not note the required use of a four wheeled walker or wheelchair for ambulation. There was no other Resident Evaluation noted in the resident's record. A review of the facility's Resident Evaluation form, conducted on , the Resident evaluation was to be completed on each resident upon admission, quarterly, and with changes in condition. A review of the facility's undated Use of Assistive Devices and Ambulatory policy and procedures, conducted on , revealed that according to the policy and procedures on page 68:	A 034		

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A 034	Continued From page 31 Implementation 1. The physician report and any pre-admission documentation will be reviewed prior to placement, identifying resident need for assistive devices or mobility . 2. The resident and responsible party are interviewed regarding the resident's need for assistive devices or mobility . 3. Upon admission, the resident's assistive devices and mobility are labeled with name and room number. 4. Upon admission, residents are instructed about use of devices/ within the community: a. Use in dining room b. Storage of devices for safety. 5. When a resident receives a new order for a mobility aid, the physician is contacted to request a , , , consult for resident teaching. 6. In the dining room or common areas where an activity may cause some , residents mobility are moved to a designated area once the resident is seated safely. Staff will return the device to the resident upon request when the resident is ready to ambulate. 7. Any residents using a motorized scooter must demonstrate safe operation of the device to the Administrator. The resident Care Coordinator also obtains a written order verifying the ability for safe operation from the resident's physician. The resident must be re-evaluated for safety should any , operation take place. 8. Safe use of mobility and assistive devices is included in staff orientation. During an interview with the memory care	A 034		

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A 034	Continued From page 32 Wellness Director, conducted on at 12:55pm, the Wellness Director agreed that Residents #1, #2, and #3's assistive devices were not clean. During an interview with the assisted living Wellness Director, conducted on at 01:45pm, the Wellness Director agreed that Residents #1, #2, and #3's records did not have the current assistive devices that the residents used documented in their records. The Wellness Director agreed that the facility did not perform Resident Evaluations according to the facility's policy and procedures upon admission, quarterly, and upon changes in conditions. The Wellness Director was unable to provide evidence that assistive devices were cleaned, and their physical condition was inspected on a regular basis. During an interview with the Administrator, conducted on at 03:45pm, the Administrator reviewed the photographic evidence of Residents #1, #2, and #3's assistive devices and agreed that the assistive devices were not clean. The Administrator was unable to provide evidence that assistive devices were cleaned, and their physical condition was inspected on a regular basis. The Administrator agreed that the facility did not perform Resident Evaluations according to their policy and procedures upon admission, quarterly, and with changes in conditions. Class III	A 034		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service	A 081		

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A 081	Continued From page 33 429.52(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 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.	A 081		

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A 081	Continued From page 34 (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 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.	A 081		

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A 081	Continued From page 35 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. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure for 4 (Staff A, Staff B, Staff C and Staff D) of 4 sampled staff, who performed direct care for residents, had all their required training completed.	A 081		

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A 081	Continued From page 36 Findings Included: During an attempted review of employee records conducted on it was revealed that Staff A who has a hire date of 11/24/2021 and who is a direct care staff, was missing documentation of all of the following required training: Pre-service training, activities of daily living (ADL) and behavioral needs training, incident reporting training, resident rights training, and recognizing , neglect, , training, elopement, safe food handling, and control. During an attempted review of employee records conducted on it was revealed that Staff B who has a hire date of and who is a direct care staff, was missing documentation of all of the following required training: Pre-service training, activities of daily living (ADL) and behavioral needs training, incident reporting training, resident rights training, and recognizing , neglect, , training, elopement, safe food handling, and control. During an attempted review of employee records conducted on it was revealed that Staff C who has a hire date of and who is a direct care staff, was missing documentation of all of the following required training: Pre-service training, activities of daily living (ADL) and behavioral needs training, incident reporting training, resident rights training, and recognizing , neglect, , training, elopement, safe food handling, and control.	A 081		

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A 081	Continued From page 37 During an attempted review of employee records conducted on it was revealed that Staff D who has a hire date of and who is a direct care staff, was missing documentation of all of the following required training: Pre-service training, activities of daily living (ADL) and behavioral needs training, elopement, safe food handling, and control. During an interview conducted on at 2:50pm with the Administrator he confirmed no trainings were available for review in the employee's records. Class III	A 081		
A 083 SS=D	59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND ( ). A staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified	A 083		

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A 083	Continued From page 38 under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure for 4 (Staff A, Staff B, Staff C and Staff D) of 4 sampled staff hold a valid card documenting completion for First Aid and , , ( ). Findings Included: During an attempted employee record review conducted on revealed that Staff A who has a hire date of was missing documentation of completion of first aid and training. During an attempted employee record review conducted on revealed that Staff B who has a hire date of was missing documentation of completion of first aid and training. During an attempted employee record review conducted on revealed that Staff C who has a hire date of was missing documentation of completion of first aid and training. During an attempted employee record review conducted on revealed that Staff D who has a hire date of was missing documentation of completion of first aid and training. During an interview conducted on at	A 083		

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A 083	Continued From page 39 2:50pm with the Administrator he confirmed no First Aid and trainings were available for review in the employee's records. Class III	A 083		
A 086 SS=D	59A-36.011(10) FAC Training - ADRD (10) AND RELATED ("ADRD") TRAINING REQUIREMENTS. Facilities which advertise that they provide special care for persons with ADRD, or who maintain secured areas as described in Chapter 4, Section 464.4.6 of the Florida Building Code, as adopted in rule 61G20-1.001, F.A.C., Florida Building Code Adopted, must ensure that facility staff receive the following training. (a) Facility staff who interact on a daily basis with residents with ADRD but do not provide direct care to such residents and staff who provide direct care to residents with ADRD, shall obtain 4 hours of initial training within 3 months of employment. Completion of the core training program between , . and , . shall satisfy this requirement. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. Initial training, entitled " and Related Level I Training," must address the following subject areas: 1. Understanding 's and related ; 2. Characteristics of ; 3. Communicating with residents with 's ; 4. Family issues;	A 086		

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A 086	Continued From page 40	A 086		

5. Resident environment; and,
6. Ethical issues.
(b) Staff who have successfully completed both the initial one hour and continuing three hours of ADRD training pursuant to sections 400.1755, 429.917 and 400.6045(1), F.S., shall be considered to have met the initial assisted living facility and Related Level I Training.
(c) Facility staff who provide direct care to residents with ADRD must obtain an additional 4 hours of training, entitled " and Related Level II Training," within 9 months of employment. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. and Related Level II Training must address the following subject areas as they apply to these :
1. Behavior management,
2. Assistance with ADLs,
3. Activities for residents,
4. Stress management for the care giver; and,
5. Medical information.
(d) A detailed description of the subject areas that must be included in an ADRD curriculum which meets the requirements of paragraphs (a) and (b) of this subsection, can be found in the document "Training Guidelines for the Special Care of Persons with 's and Related ," dated , incorporated by reference, available from the Department of Elder Affairs, 4040 Esplanade Way, Tallahassee, Florida 32399-7000.
(e) Direct care staff shall participate in 4 hours of continuing education annually as required under

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A 086	Continued From page 41 section 429.178, F.S. Continuing education received under this paragraph may be used to meet 3 of the 12 hours of continuing education required by section 429.52, F.S., and subsection (1) of this rule, or 3 of the 6 hours of continuing education for extended congregate care required by subsection (7) of this rule. (f) Facility staff who have only incidental contact with residents with ADRD must receive general written information provided by the facility on interacting with such residents, as required under section 429.178, F.S., within three (3) months of employment. "Incidental contact" means all staff who neither provide direct care nor are in regular contact with such residents. (g) Persons who seek to provide ADRD training in accordance with this subsection must provide the department or its designee with documentation that they hold a Bachelor's degree from an accredited college or university or hold a license as a registered nurse, and: 1. Have 1 year teaching experience as an educator of caregivers for persons with 's or related , or 2. Three years of practical experience in a program providing care to persons with 's or related , or 3. Completed a specialized training program in the subject matter of this program and have a minimum of two years of practical experience in a program providing care to persons with 's or related . (h) With reference to requirements in paragraph (g), a Master's degree from an accredited college or university in a subject related to the content of this training program can substitute for the teaching experience. Years of teaching experience	A 086		

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	AL11910842	A. BUILDING: _____ B. WING _____	12/29/2022

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A 086	Continued From page 42 related to the subject matter of this training program may substitute on a year-by-year basis for the required Bachelor's degree referenced in paragraph (g). This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure that 2 (Staff A, and Staff C) of 4 sample facility staff who have regular contact and/or provide direct care to residents with and Related (ADRD) have 4 hours of initial training within 3 months of hire. Findings Included: During an attempted employee record review conducted on revealed that Staff A, who has a hire date of , who provideds direct care to residents, did not have the required 4 hour ADRD training. During an attempted employee record review conducted on revealed that Staff C, who has a hire date of /202, who provideds direct care to residents, did not have the required 4 hour ADRD training. During an interview conducted on at 2:50pm with the Administrator he confirmed no trainings were available for review in the employee's records. Class III	A 086		

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A 090	Continued From page 43	A 090		
A 090 SS=D	59A-36.011(11) FAC Training -	A 090		

(11) TRAINING.
(a) Currently employed facility administrators, 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 assure 4 (Staff A, Staff B, Staff C and Staff D) of 4 sampled staff had 1-hour ( ) training.

Findings included:
During an attempted employee record review conducted on Staff A who has a hire date of did not have a certificate of completion for required 1-hour training.

During an attempted employee record review conducted on Staff B who has a hire date of did not have a certificate of completion for required 1-hour training.

During an attempted employee record review conducted on Staff C who has a hire date of did not have a certificate of

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A 090	Continued From page 44 completion for required 1-hour training. During an attempted employee record review conducted on Staff D who has a hire date of did not have a certificate of completion for required 1-hour training. During an interview conducted on at 2:50pm with the Administrator he confirmed no trainings were available for review in the employees records. Class III	A 090		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C.	A 162		

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A 162	Continued From page 45 (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C. (f) A ⌄ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their ⌄ recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to	A 162		

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A 162	Continued From page 46 or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule	A 162		

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A 162	Continued From page 47 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain an updated health assessment for a significant change in condition and admission to hospice services for one (Resident #3) of one sampled resident. Furthermore, the facility failed to obtain an interdisciplinary care plan, which specified the services provided by hospice and those provided by the facility and agreed upon by hospice, the facility, and the resident (or resident's responsible party) for one (Resident #3) of one sampled resident admitted to Hospice services. Findings Included: A record review for Resident #3, conducted on , revealed that Resident #3 was	A 162		

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A 162	Continued From page 48 admitted to hospice services on . Resident #3's undated health assessment form did not note that the resident required the nursing services of hospice and did not include the telephone number or address of the Examiner. There was no order from Resident #3's primary care physician that the resident may be admitted to hospice services. Resident #3's record did not contain an interdisciplinary care plan that specified the services that hospice provided and those that the facility provided and agreed upon by hospice, the facility, and the resident (or resident's responsible party). There was no facility admission date noted in Resident #3's record. During an interview with the Assisted Living Wellness Director, conducted on at 01:45pm, the Wellness Director agreed that Resident #3 was admitted to hospice services and that the resident's record did not contain the required information for continued residency which included an updated health assessment form upon admission to hospice services, an order that the residents may be admitted to hospice services, and an interdisciplinary care plan that specified the services that hospice provided and those that the facility provided and agreed upon by hospice, the facility, and the resident (or resident's responsible party). Class III	A 162		
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.-	CZ814		

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CZ814	Continued From page 49 (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 record review and interview the facility failed to assure 2 (Staff A and Staff B) of 4 sampled staff, are properly screened and registered with the clearinghouse within 10 business days of employment. Findings Included: During a record review conducted on	CZ814		

Agency for Health Care Administration

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CZ814	Continued From page 50 revealed Staff A who has a hire date of 11/24/2021 and Staff B who has a hire date of was not registed with facilities clearinghouse. During an interview conducted on at 2:50pm with the Administrator he confrimed [Staff A] and [Staff B] were not registered on the facilities clearinghouse. Unclassified	CZ814		