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
	AL11953318	A. BUILDING: _____ B. WING _____	C 03/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEANETTE BOSTON ALF	6916 N. 30TH STREET TAMPA, FL 33610

(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: 2023001036 and 2023002825) and a generator monitoring were conducted at Jeanette Boston ALF 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 be made	A 008		

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A 008	Continued From page 1	A 008		

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

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

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

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A 008	Continued From page 3 in the opinion of the examining health care practitioner, the individual's needs can be met in an assisted living facility; and, 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care practitioner. (b) When a health care practitioner conducts a medical examination, the examination must be recorded on the practitioner's form or on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, , , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-13531. Faxed or electronic copies of the completed form are acceptable. If AHCA Form 1823 is used, the form must be completed as instructed. 1. If the health care practitioner's form does not include all the examination items on AHCA Form 1823 or if AHCA Form 1823 is not completed fully, then the omitted items may be obtained by the administrator or designee either orally or in writing from the health care practitioner. The missing or omitted information must be obtained and documented in the resident's record within 30 days after the resident's admission to the facility. 2. Omitted or missing information received orally must include the name of the health care practitioner, the name and signature of the administrator or designee recording the information, and the date the information was provided. (c) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b).	A 008		

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A 008	Continued From page 4 (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 health assessment form that was complete and accurate for one Resident (#5) of six sampled residents. Findings Included: A record review for Resident #5, conducted on	A 008		

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A 008	Continued From page 5 , revealed that Resident #5 was admitted to the facility on . Resident #5's health assessment form dated did not include an elopement risk assessment. The health assessment form noted that Resident #2 required medication administration and required total care for bathing and . During an interview with the Fiscal Agent, conducted on at 02:30pm, the Fiscal Agent agreed that Resident #5's health assessment form did not include an elopement risk assessment. The Fiscal Agent stated that the facility did not employ licensed nurses for medication administration. The Fiscal Agent stated that the unlicensed Medication Technicians assisted Resident #5 with medications. The Fiscal Agent stated that Resident #5 did not require total care and that Resident Care Aides assisted the resident with all activities of daily living. Class III	A 008		
A 025 SS=J	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	A 025		

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A 025	Continued From page 6 must assist in making . , , ... for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of 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 appropriate care and services and supervision to meet the needs of one Resident (#3) that was known to be risk for elopements and had Reoccurring elopements. The lack of supervision and oversight placed Resident #3 at risk for harm or injury in the event of future elopements. Furthermore, the facility failed to maintain resident records with documentation of elopement events for one Resident (#3) of one sampled resident that eloped twice from the facility. Findings Included: During a phone interview with another State Agent conducted on . . . . . at 10:51am, the State Agent stated that Resident #3 eloped from the facility in . . . . . (day not known) and again on . The State Agent stated that the facility's Fiscal Agent stated that Resident #3 was supposed to have 1:1 care staff, that there were supposed to be two staff on duty, and that the doors were supposed to be alarmed. The State Agent stated that during his visit to the facility there was one staff on duty and no alarms on the doors. During an observation conducted on . . . . . beginning at 10:00am, the facility comprised of three buildings which included the main building (resident rooms, bathrooms, and kitchen), the activity building, and the office/laundry building. There was one staff present to provide oversight	A 025		

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A 025	Continued From page 8 to the three buildings and six residents. At 10:20am, Resident #1, Resident #3, and Staff A (Medication Technician and Resident Care Aide) were in the main building and Resident #2, Resident #4, Resident #5, and Resident #6 were in the activity building with no staff present. Staff A brought the Surveyor to the activity room and left Resident #3 without staff present in the main building. On . . . . . , a record review of Resident #2 Health Assessment form dated 1revealed a diagnosis of "forgetful". On . . . . . , a record review of Resident #4 Health Assessment form dated revealed a diagnosis of "forgetful". During an interview with Staff A, conducted on at 10:20am, Staff A stated that Resident #3 had to be watched closely because Resident #3 would leave. Staff A stated that it was difficult to watch Resident #3 closely with cleaning and cooking duties and bathing, , and toileting assistance to the other residents. During an interview with Staff A, conducted on at 02:35pm, Staff A stated that Resident #3 had eloped from the facility twice, but she was not sure of the exact dates of the elopements. During an observation conducted on . . . . . from 02:40pm until after 03:19pm, Resident #3 was in the activity building with other residents and there was no staff present. The activity building was not surrounded by a secured fence. No staff checked on Resident #3 from 02:35pm through 02:55pm. At 03:19pm, the side door to the main building leading to the outside between	A 025		

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A 025	Continued From page 9 the office/laundry building and main building was wide open and Staff A was observed in the front driveway interacting with a person that had just drove up. The Administrator and the Fiscal Agent were in the office/laundry building. There were no alarms for either exit door to the activity building or any doors to the main building. A record review for Resident #3, conducted on , revealed that Resident #3's date of admission was not noted in the resident's record. Resident #3's health assessment form dated noted that the resident had a diagnosis of Major and was an elopement risk. Resident #3 required supervision with and assistance with bathing, grooming, toileting, and self-administration of medications. Resident #3 required daily observation for wellbeing, whereabouts, and reminders for important tasks. There was no documentation regarding an elopement that took place on or near . There was no evidence that Resident #3's primary care provider and responsible party were notified related to the resident's two elopements. During an interview with the Fiscal Agent, conducted on at 02:27pm, the Fiscal Agent stated that the facility issued Resident #3 a 45-day notice of residency termination related to a higher level of care needed for a locked facility. At 03:10pm, the Fiscal Agent was unable to provide the document or a date the notice was issued. A record review for Resident #3, conducted on , revealed there were two witness statements that noted exit seeking behaviors on prior to the resident's elopement on or near . There was one other witness	A 025		

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A 025	Continued From page 10 statement regarding Resident #3's elopement on elopement. The statements included: The first witness statement dated (no time noted), Staff B (Medication Technician and Resident Care Aide) noted that Resident #3 "walked most of the night trying to go downtown police station for her care and she took off her clothes and she moved everything in her and she was sick and tired of everybody telling her what to do and not to do and she is a grown woman and she said she have to get out of this place". The second witness statement dated at 08:00pm, Staff B noted that Resident #3 "was accompanied by her daughter and had supper that her daughter brought for her and shortly after she went to bed and then got up walked all night and said that she was trying to go downtown to the bank, and she turned on the water faucet and set off the fire alarm at 02:10am. She said she was going to the bank and Staff B told her that it was night and so she must get some sleep and that she would go to the bank for her tomorrow and Resident #3 finally laid down at 04:30am and was not sleeping and she packed everything up and she was ready to go". The third witness statement dated during the 05:00pm - 09:00am shift at 08:10am, Staff B noted that Resident #3 came to the medication room and told Staff that she wanted her shoes and that she was going downtown for her car. Staff B tried to take her to the television room and told her that she could not leave by herself. Later (no time identified), Staff B went to the medication room and finished medications and went to the kitchen and started doing the dishes from breakfast. Resident #2 asked Staff B	A 025		

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A 025	Continued From page 11 where Resident #3 was, and Staff B told Resident #2 that Resident #3 was in the television room watching television. Resident #2 told Staff B that Resident #3 was not in the television room. Staff B searched the house and yard and did not find Resident #3. Staff B immediately informed the Fiscal Agent that Resident #3 was missing and began going down the street to search for the resident and did not find the resident. Law Enforcement brought Resident #3 to the facility at 09:00am. Resident #3 stated that she went to go downtown to the soldier camp to see her daughter. There was no evidence that the facility provided additional care and services or interventions to prevent future elopements for Resident #3 when she was exit-seeking on or after the elopements on or near and . On an attempt was made to review in-house incident reports, investigation, and adverse incident reports regarding Resident #3's elopements none were available for review. During an interview with the Fiscal Agent, conducted on at 02:27pm, the Fiscal Agent stated that the in-house incident reports and adverse incident reports were unable to be located. The Fiscal Agent stated that Resident #3 eloped from the facility in and on . He stated that the elopement in was on or near the documentation of the exit seeking behaviors on . A review of the staffing schedule, conducted on , revealed that the facility did not have a true accounting of the facility's twenty-four hours staffing pattern. There was no staffing	A 025		

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A 025	Continued From page 12 schedule to review for . . . . . and . During an interview with the Fiscal Agent, conducted on . . . . . at 02:30pm, the Fiscal Agent stated that he spoke with all the staff on . . . . . regarding the facility's elopement policy and procedures. The Fiscal Agent stated that he told staff to make sure that all the doors were locked behind them. The Fiscal Agent stated that he told staff to use the . . . door to the kitchen and keep the other doors locked. The Fiscal Agent stated that staff were supposed to check on residents in the activity building every ten minutes. The Fiscal Agent stated that Resident #3's responsible party was actively working on relocating Resident #3. The Fiscal Agent was unable to provide documentation that the facility had assisted Resident #3's responsible party with relocation efforts for Resident #3 and stated that the facility allowed Resident #3 to continue residency "until she goes to a secured facility". During an interview with the Fiscal Agent, conducted on at 03:01pm, the Fiscal Agent stated that staff were to make sure that they have Resident #3 with them and to take Resident #3's shoes from her when she was not outside to prevent the resident from eloping and that staff were not supposed to take their . . . off Resident #3. During an interview with the Administrator, conducted on . . . . . at 03:00pm, the Administrator stated that staff were not supposed to take their . . . off Resident #3 and that staff were to make sure that Resident #3 was with them and take the resident everywhere the staff went and not leave Resident #3 alone. The	A 025		

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A 025	Continued From page 13 Administrator was unable to explain how one staff working with six residents could keep Resident #3 with them during their cooking and cleaning duties and during assisting the other residents with of bathing, toileting, and [illegible] assistance for other residents when only one staff was on duty for an in-house census of six residents. The Administrator stated that Resident #2 was Resident #3's roommate. The Administrator stated that staff could also leave Resident #3 near Resident #2 and that Resident #2 kept an [illegible] on Resident #3 and that "it's not like [Resident #3] elopes all the time". The Administrator was unable to provide evidence that the facility had issued a 45-day notice of residency termination to Resident #3 (and/or responsible party). Class I	A 025		
A 032 SS=J	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children	A 032		

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	AL11953318	A. BUILDING: _____ B. WING _____	C 03/01/2023

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A 032	Continued From page 14 and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and,	A 032		

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A 032	Continued From page 15 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure proper elopement response standards were in place which placed one Resident (#3) of one sampled resident at risk for elopements. Furthermore, the facility failed to conduct elopement drills with all staff twice per year as required. The facility's noncompliance placed Resident #3 at great risk of harm or injury related reoccurring elopements. Findings Included: During an interview with another State Agent, conducted on at 10:51am, the State Agent stated that Resident #3 eloped from the facility in , (exact day not known) and again on . During observations, conducted on at 10:05am, Staff A left Resident #3 in the main building and there was no staff present. From 02:40pm through 03:19pm, Resident #3 was in the activity building and there was no staff present. The facility was not a locked and secured facility. Resident #3 did not have identification on her person. During an interview with Staff A, conducted on at 10:20am, Staff A did not provide requested resident, facility, and employee records. Staff A stated that she did not have access to any records. Staff A stated that	A 032		

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A 032	Continued From page 16 Resident #3 has left the facility and had to be watched closely. At 02:35pm, Staff A stated that the facility did not have a photograph of Resident #3 that she knew of. Staff A stated that Resident #3 eloped from the facility on two occasions. Staff A was not able to provide the exact dates of Resident #3's elopements. A review of the facility's undated elopement response policy and procedures, conducted on [redacted], the elopement response policy and procedures stated that: Purpose: the following procedure is to be followed when and if a resident elopes or leave the facility without permission 1. Identify missing person 2. Make a complete search of the facility and grounds (after complete search) 3. Continue to search if applicable 4. Notify the [police department] and have available the following info: A. Residents [redacted], hair color, clothing last seen wearing, usual behaviors of the resident and any visible scars or tattoos that are easily recognizable B. Give a picture of the Resident if available C. Staff to have Resident's file available for any other questions [Police Department] may need 5. Notify administrator or designated staff about the missing person so that they can make decision for appropriate community contact 6. Notify guardian of family member of the incident 7. Notify guardian of family member of the incident 8. Do not take any calls from the Media refer all calls to the Administrator (take number for call [redacted]) 9. When Resident is located or found without	A 032		

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A 032	Continued From page 17 [Local Police Department] notify them immediately 10. Complete incident report The facility's elopement response policy and procedures did not include: -An immediate search of the facility and premises -The identification of staff responsible for implementing each part of the elopement response policy and procedures -The staff specific duties and responsibilities -The identification of the staff responsible for contacting law enforcement, the resident's responsible party, the case manager, and the State Agencies A record review for Resident #3, conducted on [redacted], revealed that according to Resident #3's health assessment dated [redacted] the resident had a diagnosis of Major [redacted] and was at risk for elopements. There was no photograph of Resident #3 in the resident's record or medication observation record. There was no documentation in Resident #3's record regarding the elopement in [redacted]. However, there were two witness statements by Staff B dated (no time noted) regarding exit seeking behaviors displayed by Resident #3. The statements noted that Resident #3 was walking most of the night and made statements such as "trying to go downtown to the police station", "going to the bank" and "have to get out of this place" and packing up her belongings. There was a witness statement written by Staff B on [redacted] at 08:10am that noted Resident #3 made comments that "she was going downtown for her car" and Resident #3 was missing some time afterward. Law enforcement brought Resident #3 to	A 032		

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A 032	Continued From page 18 the facility at 09:00am. During an attempt to review the facility's elopement drills, conducted on , there were none provided by the facility. During an interview with the Fiscal Agent, conducted on at 02:30pm, the Fiscal Agent stated that he spoke with all the staff on regarding the facility's elopement policy and procedures. He stated he told the staff to make sure that all the doors were locked behind them and for staff to use the door to the kitchen and the other doors were supposed to be kept locked. The Fiscal Agent stated that staff were supposed to check on residents in the activity building every ten minutes. During an attempt to review the staff in-service regarding a review of the facility's elopement policy and procedures on , conducted on , the sign-in sheet was viewed on the Fiscal Agents computer. There were no staff signatures of attendance. During an interview with the Fiscal Agent, conducted on at 03:01pm, the Fiscal Agent stated that staff were to make sure that they have Resident #3 with them and to take Resident #3's shoes from her when she was not outside to prevent the resident from eloping and that staff were not supposed to take their off Resident #3. The Fiscal Agent was unable to provide evidence that the facility conducted elopement drills with all staff twice per year. During an interview with the Administrator, conducted on at 03:00pm, the Administrator stated that staff were not supposed to take their off Resident #3 and that staff	A 032		

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A 032	Continued From page 19 were to make sure that Resident #3 was with them and take the resident everywhere the staff went and not leave Resident #3 alone. The Administrator stated that Resident #2 (noted as "forgetful" on her health assessment) was Resident #3's roommate. The Administrator stated that staff could leave Resident #3 near Resident #2 because Resident #2 kept an ´ on Resident #3. The Administrator stated that "it's not like [Resident #3] elopes all the time". The Administrator was unable to provide evidence that the facility conducted elopement drills with all staff twice per year. Class I	A 032		
A 078 SS=D	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	A 078		

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A 078	Continued From page 20 submit a health care provider's statement that the individual does not constitute a risk of [redacted]. 2. If any staff member has, or is suspected of having, a communicable [redacted], 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 [redacted]. (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	A 078		

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A 078	Continued From page 21 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 a one-time statement that the employee was free from signs and symptoms of communicable . . . . . from a health care provider for one employee (Staff D) of six sampled employees. Furthermore, the facility failed to obtain evidence of a negative . . . . . (.) examination annually for six employees (Administrator, Fiscal Agent, Staff A, Staff B, Staff C, and Staff D) of six sampled employees. Findings Included: A review of the Administrator's employee record, conducted on . . . . . , revealed that the Administrator's record did not have evidence of a negative . examination annually. The last negative examination was dated . The Administrator was hired on . . . . . . A review of the Fiscal Agent's employee record, conducted on , revealed that the Fiscal Agent's record did not have evidence of a negative examination annually. The last negative . examination was dated . . . . The Fiscal Agent was hired on . A review of Staff A's employee record, conducted on . . . . . , revealed that Staff A's record did not have evidence of a negative examination annually. The last negative . examination was dated . Staff A was hired on	A 078		

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A 078	Continued From page 22 A review of Staff B's employee record, conducted on , revealed that Staff B's record did not have evidence of a negative examination annually. The last negative examination was dated . Staff B was hired on . A review of Staff C's employee record, conducted on , revealed that Staff C's record did not have evidence of a negative examination annually. The last negative examination was dated . Staff C was hired on . A review of Staff D's employee record, conducted on , revealed that Staff D's record did not have a one-time statement that the employee was free from signs and symptoms of communicable from a health care provider. Staff D's record did not contain evidence of a negative examination. There was no date of hire noted in Staff D's employee record. During an interview with the Fiscal Agent, conducted on at 02:35pm, the Fiscal Agent agreed that employee records for the Administrator, Fiscal Agent, Staff A, Staff B, Staff C, and Staff D did not contain evidence of a negative examination annually. The Fiscal Agent agreed that Staff D's employee record did not contain a one-time statement that the employee was free from signs and symptoms of communicable from a health care provider. During an interview with the Administrator, conducted on at 04:00pm, the Administrator was unable to provide evidence that the Administrator, Fiscal Agent, Staff A, Staff B, Staff C, and Staff D had a negative	A 078		

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A 078	Continued From page 23 examination annually. The Administrator was unable to provide evidence that Staff D had a one-time statement that the employee was free from communicable . . . from a health care provider. Class III	A 078		
A 079 SS=D	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents — Staff Hours/Week 0-5 — 168 . . . — 212 16-25 — 253 26-35 — 294 36-45 — 335 46-55 — 375 56-65 — 416 66-75 — 457 76-85 — 498 86-95 — 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to	A 079		

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A 079	Continued From page 24	A 079		

facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility.
4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night.
5. A staff member who has completed courses in First Aid and , , , . ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times.
a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement.
b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and .
6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least , , must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager.
7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement.
8. The administrator or manager's time may be

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A 079	Continued From page 25 counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required.	A 079		

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A 079	Continued From page 26 Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have a staff schedule that reflected its twenty-four hours staffing pattern for , . Furthermore, the facility failed to have at	A 079		

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	AL11953318	A. BUILDING: _____ B. WING _____	C 03/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEANETTE BOSTON ALF	6916 N. 30TH STREET TAMPA, FL 33610

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A 079	Continued From page 27 least one staff member that had access to facility, staff and resident records in the event of an emergency. Findings Included: During an observation, conducted on . . . . . at 10:00am, Staff A (Medication Technician/Resident Care Aide) was working alone in the facility. Staff B (Medication Technician/Resident Care Aide) arrived at 04:45pm. A review of the staffing schedule for Wednesdays, conducted on . . . . . , revealed that the staffing schedule did not accurately reflect the facility's twenty-four hours staffing pattern as the Administrator was scheduled to work on . . . . . from 8 to 5. The am and pm were not noted for any shift times (photographic evidence obtained). Staff B was scheduled on Wednesdays from 9 to 9. Staff C (Medication Technician/Resident Care Aide) was scheduled every Monday from 5 to 9. Staff D (Medication Technician/Resident Care Aide) was scheduled on Sundays from 8 to 5, Wednesdays from 5 to 9, Fridays from 5 to 9, and Saturdays from 8 to 5. During an attempt to review facility, resident, and employee records, conducted on at 10:05am, Staff A did not provide the facility, resident, and employee records. During an interview with Staff A, conducted on . . . . . at 10:27am, Staff A stated that facility, resident, and employee records were under lock and key and that she was unable to provide the records. During an interview with the Fiscal Agent,	A 079		

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A 079	Continued From page 28 conducted on . . . . . at 11:00am, the Fiscal Agent stated that Staff C and Staff D work occasionally and fill in during staffing emergencies. The Fiscal Agent stated that Staff C last worked about a month ago. The Fiscal Agent was unable to provide Staff D's last day worked. The Fiscal Agent agreed that the staffing schedule was not a true reflection of the facility's staffing pattern. Class III	A 079		
A 080 SS=D	429.52( ) FS; 59A-36.011(1) FAC Training - Core & Competency Test 429.52 (2) Administrators and other assisted living facility staff must meet minimum training and education requirements established by the agency by rule. This training and education is intended to assist facilities to appropriately respond to the needs of residents, to maintain resident care and facility standards, and to meet licensure requirements. (3) The agency, in conjunction with providers, shall develop core training requirements for administrators consisting of core training learning objectives, a competency test, and a minimum required score to indicate successful passage of the core competency test. The required core competency test must cover at least the following topics: (a) State law and rules relating to assisted living facilities. (b) Resident rights and identifying and reporting , neglect, and . (c) Special needs of elderly persons, persons with mental illness, and persons with . . . . . and how to meet those needs. (d) Nutrition and food service, including	A 080		

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A 080	Continued From page 29 acceptable sanitation practices for preparing, storing, and serving food. (e) Medication management, recordkeeping, and proper techniques for assisting residents with self-administered medication. (f) Firesafety requirements, including fire evacuation drill procedures and other emergency procedures. (g) Care of persons with [illegible]'s [illegible] and related [illegible]. 59A-36.011 (1) ASSISTED LIVING FACILITY CORE TRAINING REQUIREMENTS AND COMPETENCY TEST. (a) The assisted living facility core training requirements established by the department pursuant to section 429.52, F.S., shall consist of a minimum of 26 hours of training plus a competency test. (b) Administrators and managers must successfully complete the assisted living facility core training requirements within 3 months from the date of becoming a facility administrator or manager. Successful completion of the core training requirements includes passing the competency test. The minimum passing score for the competency test is 75%. Administrators who have attended core training prior to [illegible], and managers who attended the core training program prior to [illegible], shall not be required to take the competency test. Administrators licensed as nursing home administrators in accordance with chapter 468, part II, F.S., are exempt from this requirement. (c) Administrators and managers shall participate in 12 hours of continuing education in topics related to assisted living every 2 years. (d) A newly hired administrator or manager who	A 080		

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A 080	Continued From page 30 has successfully completed the assisted living facility core training and continuing education requirements, shall not be required to retake the core training. An administrator or manager who has successfully completed the core training but has not maintained the continuing education requirements will be considered a new administrator or manager for the purposes of the core training requirements and must: 1. Retake the assisted living facility core training; and, 2. Retake and pass the competency test. (e) The fees for the competency test shall not exceed $200.00. The payment for the competency test fee shall be remitted to the entity administering the test. A new fee is due each time the test is taken. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide evidence that the Administrator satisfied a minimum of twelve continuing education every two years for assisted living facility core training requirements. Findings Included: An employee record review for the Administrator, conducted on [redacted], revealed that the Administrator did not have evidence that of obtaining twelve hours of continuing education credits every two years for assisted living facility core training requirements since obtaining assisted living core training on [redacted]. During an interview with the Fiscal Agent, conducted on [redacted], the Fiscal Agent was unable to provide evidence that the Administrator	A 080		

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A 080	Continued From page 31 completed twelve hours of continuing education every two years since obtaining core training on Class III	A 080		
A 081 SS=D	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 living facility employees who have not previously	A 081		

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A 081	Continued From page 32 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 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	A 081		

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A 081	Continued From page 33 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 34 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide direct care staff with the required in-service trainings, within thirty days of hire for five employees (Fiscal Agent, Staff A, Staff B, Staff C, and Staff D) of five sampled employees. Findings Included: An employee record review for the Fiscal Agent, conducted on . . . . . , revealed that the Fiscal Agent's employee record did not contain evidence that the employee had training regarding activities of daily living and behavioral needs, adverse incident reporting, and resident rights and recognizing and reporting , neglect, and , ... trainings within thirty days of hire. The Fiscal Agent was hired on . . . . . . A review of the . . . . . staffing schedule, conducted on , revealed that the Fiscal Agent was scheduled to provide direct care on Sundays, Mondays, and Tuesdays from (no am or pm noted) and Tuesdays and Thursdays from (no am or pm noted) (photographic evidence obtained). An employee record review for Staff A, conducted on , revealed that Staff A's employee record did not contain evidence that the employee had training regarding adverse incident reporting, and resident rights and recognizing and reporting , neglect, and , trainings within thirty days of hire. Staff A was hired on . An employee record review for Staff B, conducted	A 081		

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A 081	Continued From page 35 on . . . . . , revealed that Staff B's employee record did not contain evidence that the employee had training regarding activities of daily living and behavioral needs, adverse incident reporting, and resident rights and recognizing and reporting , neglect, and , trainings within thirty days of hire. Staff B was hired on . An employee record review for Staff C, conducted on . . . . . , revealed that Staff C's employee record did not contain evidence that the employee trainings regarding a two-hours pre-service orientation prior to direct care. Staff C's employee record did not contain evidence that the employee had trainings regarding activities of daily living and behavioral needs, adverse incident reporting, and resident rights and recognizing and reporting . . . . . , neglect, and , ... trainings within thirty days of hire. Staff C was hired on . . . . . . An employee record review for Staff D, conducted on , revealed that Staff D's employee record did not contain evidence that the employee trainings regarding a two-hours pre-service orientation and control prior to direct care. Staff D's employee record did not contain evidence that the employee had trainings regarding activities of daily living and behavioral needs, adverse incident reporting, emergency procedures, nutrition and safe food handling, and resident rights and recognizing and reporting , neglect, and , trainings within thirty days of hire. Staff D had an unknown date as this was not noted in the employee's record. During an interview with the Fiscal Agent, conducted on at 02:35pm, the Fiscal Agent was unable to provide the training	A 081		

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A 081	Continued From page 36 documents for the Fiscal Agent, Staff A, Staff B, Staff C, and Staff D. 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 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 observation, record review and interview, the facility failed to provide staff on each shift with training in , , , ( ) and first aid for three employees (Staff A, Staff B, and Staff D) of six sampled employees.	A 083		

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A 083	Continued From page 37 Findings Included: During an observation, conducted on . . . . . from 10:00am through 10:34am, Staff A worked alone in the facility. An employee record review for Staff A, conducted on , revealed that Staff A obtained . training on . . . . . and had expired on . There was no evidence in Staff A's record that the employee obtained first aid training. An employee record review for Staff B, conducted on . . . . . , revealed that Staff B obtained and first aid training on and both trainings had expired on . . . . . . An employee record review for Staff D, conducted on , revealed that there was no evidence in Staff D's record that the employee obtained and first aid training. During an interview with the Fiscal Agent, conducted on . . . . . at 03:30pm, the Fiscal Agent was unable to provide evidence of current and valid . and first aid training for Staff A, Staff B, and Staff D. Class III	A 083		
A 084 SS=D	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the	A 084		

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A 084	Continued From page 38 self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, , dosage forms, and , , , and dosage forms; b. Measure liquid medications, break scored	A 084		

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A 084	Continued From page 39 tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with syringes that are prefilled with the proper dosage by a pharmacist and that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection; i. Assist with ; j. Use a to perform testing; k. Assist residents with and continuous positive airway pressure (CPAP) devices, excluding the titration of the levels; l. Apply and remove stockings and hosiery; m. Placement and removal of bags, excluding the removal of the or manipulation of the site; and, n. Measurement of , rate, temperature, and , rate. (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training,	A 084		

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A 084	Continued From page 40 must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain six-hours of training regarding self-administration of medications prior to assisting residents with medications for one employee (Staff D) of six sampled employees. Furthermore, the facility failed to obtain two-hours of continuing education on assistance with self-administration of medications and safe medication practices for five employees (Administrator, Fiscal Agent, and Staff A, Staff B,	A 084		

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	AL11953318	A. BUILDING: _____ B. WING _____	C 03/01/2023

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A 084	Continued From page 41 and Staff C) of five sampled employees that provided assistance with self-administration of medications. Findings Included: A record review for the Administrator, Fiscal Agent, Staff A, Staff B, and Staff C, conducted on . . . . . , revealed there was no evidence that the Administrator, Fiscal Agent, and Staff A, Staff B, and Staff C had obtained two-hours of continuing education on assistance with self-administration of medications or safe medication practices in their employee records. The Administrator, Fiscal Agent, and Staff A were hired on . . . . . . Staff B was hired on . . . . . Staff C was hired on 11/02//2020. A record review for Staff D, conducted on . . . . . , revealed that Staff D did not have a six-hours training for assistance with self-administration of medications. Staff D's date of hire was not noted in the employee's record. During an interview with the Fiscal Agent, conducted on . . . . . at 02:35pm, the Fiscal Agent agreed that the Administrator, Fiscal Agent, and Staff A, Staff B, and Staff C had not obtained two-hours continuing education regarding assistance with self-administration of medications and safe medication practices. The Fiscal Agent stated that Staff D occasionally provided residents with assistance with self-administration of medications. During an interview with the Administrator, conducted on . . . . . at 04:00pm, the Administrator agreed that the Administrator, Fiscal Agent, Staff A, Staff B, and Staff C had not obtained two-hours continuing education	A 084		

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A 084	Continued From page 42 regarding assistance with self-administration of medications and safe medication practices. The Administrator agreed that Staff D did not have evidence of obtaining a six-hours training for assistance with self-administration of medications. Class III	A 084		
A 091 SS=D	59A-36.011(12) FAC Training - Documentation & Monitoring (12) TRAINING DOCUMENTATION AND MONITORING. (a) Except as otherwise noted, certificates, or copies of certificates, of any training required by this rule must be documented in the facility's personnel files. The documentation must include the following: 1. The title of the training program, 2. The subject matter of the training program, 3. The training program agenda, 4. The number of hours of the training program, 5. The trainee's name, dates of participation, and location of the training program, 6. The training provider's name, dated signature and credentials, and professional license number, if applicable. (b) Upon successful completion of training pursuant to this rule, the training provider must issue a certificate to the trainee as specified in this rule. (c) The facility must provide the Department of Elder Affairs and the Agency for Health Care Administration with training documentation and training certificates for review, as requested. The department and agency reserve the right to attend and monitor all facility in-service training, which is intended to meet regulatory	A 091		

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A 091	Continued From page 43 requirements. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have training certificates with the number of hours of the training program for six employees (Administrator, Fiscal Agent, Staff A, Staff B, Staff C, and Staff D) of six sampled employees. Findings Included: A review of elopement training certificates for the Administrator, Fiscal Agent, Staff A, Staff B, Staff C, and Staff D, conducted on , revealed that the elopement training certificates obtained on did not include the number of hours of the training. A review of training certificates for the Fiscal Agent, Staff A, Staff B, and Staff C, conducted on , revealed the training certificates did not include the number of hours of the training. The Fiscal Agent, Staff A, and Staff C obtained the training on and Staff B obtained the training on . A record review for the Administrator, Fiscal Agent, Staff A, Staff B, Staff C, and Staff D, conducted on , revealed that the Administrator was hired on . The Fiscal Agent was hired on . Staff A was hired on . Staff B was hired on . Staff C was hired on 11/02/2020. There was no date of hire in Staff D's employee record. During an interview with the Fiscal Agent, conducted on at 02:35pm, the Fiscal Agent agreed that the training certificates for the	A 091		

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A 091	Continued From page 44 Administrator, Fiscal Agent, Staff A, Staff B, Staff C, and Staff D did not include the number of hours of the training. Class III	A 091		
A 160 SS=D	59A-36.015(1) FAC Records - Facility The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a [redacted]; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to rule 59A-36.018, F.A.C. If the resident dies while in the care of the	A 160		

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A 160	Continued From page 45 facility, the log must indicate the date of . . . . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with . . . . 's . . . . or related . . . . . , a copy of all such facility advertisements as required by section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in rule 59A-36.007, F.A.C. (j) All food service records required in rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to section 429.41, F.S., and rule chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the	A 160		

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A 160	Continued From page 46 county health department pursuant to section 381.031, F.S., and chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain an up-to-date admission and discharge log that included residents' dates and places of admission for four Residents (#2, #4, #5, and #6) of six sampled residents. Furthermore, the admission and discharge log did not include dates, reasons, and places of discharge for two former Residents (#7 and #8) of two sampled discharged residents. Findings Included: A review of the admission and discharge log, conducted on , revealed that the admission and discharge log did not include Residents #2, #4, #5, and #6's dates of admission or the places from where they were admitted. There were no dates of discharge, reasons for discharge, or the places that the residents were discharged to for Residents #7	A 160		

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A 160	Continued From page 47 and #8. During an interview with the Fiscal Agent, conducted on at 11:45am, the Fiscal Agent agreed that the admission and discharge log did not include the dates and place of admission for Residents #2, #4, #5, and #6. The Fiscal Agent agreed that there were no dates, reason, and places of discharge for former Residents #7 and #8. Class III	A 160		
A 161 SS=D	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	A 161		

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A 161	Continued From page 48 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 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 ˬ 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 maintain personnel records with an application that included references for one employee (Staff D) of six sampled employees. Findings Included: A review of the ˬ staffing schedule, conducted on , revealed that Staff D	A 161		

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A 161	Continued From page 49 was scheduled to work on Sundays, Wednesdays, Fridays, and Saturdays (photographic evidence obtained). An employee record review for Staff D, conducted on , revealed that Staff D's employee record did not include an application with references. There was no date of hire noted in Staff D's employee record. During an interview with the Fiscal Agent, conducted on at 02:35pm, the Fiscal Agent agreed that Staff D did not have an employee record and was unable to provide an application with references for the employee. Class III	A 161		
A 165 SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in:	A 165		

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A 165	Continued From page 50 1. [illegible]; 2. [illegible] or [illegible] damage; 3. Permanent [illegible]; 4. [illegible] or [illegible] of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) [illegible], neglect, or [illegible] 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,	A 165		

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A 165	Continued From page 51 chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to submit adverse incident reports to The Agency for one Resident (#3) of one sampled resident that eloped from the facility on two occasions. Findings Included:	A 165		

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A 165	Continued From page 52 During an interview with another State Agent, conducted on [redacted] at 10:51am, the State Agent stated that Resident #3 eloped from the facility in [redacted] (day not known) and again on [redacted]. During an interview with Staff A, conducted on [redacted] at 02:35pm, Staff A stated that Resident #3 eloped from the facility on two occasions. Staff A was not able to provide the exact dates of Resident #3's elopements. During an attempt to review adverse incident reports submitted to the Agency for Resident #3, conducted on [redacted], revealed that there were no adverse incident reports to review. A record review for Resident #3, conducted on [redacted], revealed that there was a witness statement by Staff B regarding Resident #3's elopement on [redacted]. There was no documentation regarding an earlier elopement in [redacted]. However, there were two witness statements regarding exit seeking behaviors prior to Resident #3's elopement on or near [redacted] by Staff B. During an interview with the Fiscal Agent, conducted on [redacted] at 02:27pm, the Fiscal Agent stated that the in-house incident reports and adverse incident reports were unable to be located. The Fiscal Agent stated that Resident #3 eloped from the facility in [redacted] and on [redacted]. He stated that the elopement in [redacted] was on or near the documentation of the exit seeking behaviors on [redacted]. Class III	A 165		

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A 170	Continued From page 53	A 170		
A 170 SS=D	429.24(3)a Resident Refund Policy ....The facility shall provide a refund to the resident or responsible party within 45 days after the transfer, discharge, or . . . . of the resident. The agency shall impose a fine upon a facility that fails to comply with the refund provisions of the paragraph, which fine shall be equal to three times the amount due to the resident. One-half of the fine shall be remitted to the resident or his or her estate, and the other half to the Health Care Trust Fund to be used for the purpose specified in s. 429.18. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide a refund within 45-days of transfer to one Resident (#8) of one sampled resident that discharged to a higher level of care. Findings Included: During an interview with the Business Office Manager at the receiving facility, conducted on . . . . . at 09:19am, the Business Office Manager stated that Resident #8 was admitted to their facility on . . . . The Business Office Manager stated that they became Resident #8's Representative Payee and began receiving Resident #8's monthly government funds . . . . The Business Office Manager stated that the facility continued to receive Resident #8's monthly government funds from . . . . . through . . . . . The Business Office Manager stated that the Fiscal Agent gave the receiving facility a one-time check in the amount of $700.00 on one occasion and that the facility continued to owe the receiving facility $4333.00.	A 170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11953318	A. BUILDING: _____ B. WING _____	C 03/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEANETTE BOSTON ALF	6916 N. 30TH STREET TAMPA, FL 33610

(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 170	Continued From page 54 A review of the admission and discharge log, conducted on , revealed that Resident #8 was not listed as a current or former resident of the facility. During an interview with the Fiscal Agent, conducted on at 11:00am, the Fiscal Agent agreed that Resident #8 was a former resident. The Fiscal Agent was not able to provide Resident #8's admission and discharge dates. At 11:45am, the Fiscal Agent was unable to locate the admission and discharge log that listed Resident #8 as a resident. A record review of the resident record for Resident #8, conducted on , revealed that there was no admission and discharge dates listed in the resident's record. According to Resident #8's health assessment form dated , Resident #8 had a diagnosis of and was . Resident #8's rate contract dated noted a rate of $794.00 per month to be paid to the facility. Resident #8's record noted a social security income in the amount of $794.00. An additional payment source was noted as $1300.00 per month from a government agency. The refund policy sections of the resident contract noted that refunds would be provided 45 days following the final date of termination of residency. The resident contract also noted that residents discharged due to medical or needs beyond what the facility could provide would be issued a full refund for the unused days. On an attempt was made to review social security funds received by the facility for Resident #8 between through , the documents were not provided to review.	A 170		

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A 170	Continued From page 55 On to review social security funds sent to the government agency for Resident #8 between through , the documents were not provided. On an attempt was made to review payments made to the receiving facility for Resident #8 from through , the documents were not provided. During an interview with the Fiscal Agent, conducted on at 02:15pm, the Fiscal Agent stated that he was unable to provide the admission and discharged log that noted Resident #8's date of admission and the resident's date of discharge. The Fiscal Agent was unable to provide evidence of monthly social security funds received for Resident #8. The Fiscal Agent was unable to provide evidence that the facility sent the social security funds to the government agency. The Fiscal Agent was unable to provide evidence that the facility made payments to the receiving facility for Resident #8. At 02:29pm, the Fiscal Agent stated that I can't provide any documents. During an interview with the Administrator, conducted on at 02:25pm. The Administrator stated that the government agency instructed the facility to send the monthly funds for Resident #8 to the government agency. The Administrator stated that the facility continued to receive social security funds for Resident #8 for four months and the checks kept coming to the facility. Class III	A 170		

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CZ813	Continued From page 56	CZ813		
CZ813	59A-35.090(3)(c), FAC Results of Screening & Notification In File 59A-35.090 Background Screening. (3) Results of Screening and Notification. (c) The eligibility results of employee screening and the signed Attestation referenced in subsection 59A-35.090(2), F.A.C., must be in the employee's personnel file, maintained by the provider. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that employee records were maintained with proof of an eligible level 2 background screening for two employees (Staff A and Staff B) of six sampled employees. Findings Included: An employee record review for Staff A, conducted on , revealed that the eligible level 2 background screening was dated . Staff A was hired on . An employee record review for Staff B, conducted on , revealed that the eligible level 2 background screening was dated . Staff B was hired on . During an interview with the Fiscal Agent, conducted on at 02:35pm, the Fiscal Agent stated that the employees did have an eligible background screening but that he had not printed them or added the current screenings to Staff A and Staff B employee records. Unclassified	CZ813		

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CZ814	Continued From page 57	CZ814		
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the , are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic , submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain the employment status of employees within the facility's background screening clearinghouse employee roster for one employee (Staff D) of six sampled employees.	CZ814		

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CZ814	Continued From page 58 Findings Included: A review of the facility's background screening clearinghouse employee roster, conducted on [redacted], revealed that Staff D was not listed as a current employee of the facility. A review of the [redacted] staffing schedule, conducted on [redacted], revealed that Staff D was scheduled to work the entire of [redacted] on Sundays, Wednesdays, Fridays, and Saturdays (photographic evidence obtained). During an interview with the Fiscal Agent, conducted on [redacted] at 02:35pm, the Fiscal Agent agreed that the facility background clearinghouse employee roster was not up to date and Staff D was not listed as a current employee of the facility. Unclassified	CZ814		
CZ815	408.809(1)( ); 435.02(2); 435.06 FS Background Screening; Prohibited Offenses 408.809 Background screening; prohibited offenses.- (1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are considered employees for the purposes of conducting screening under chapter 435: (a) The licensee, if an individual. (b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider. (c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider.	CZ815		

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CZ815	Continued From page 59 (d) Any person who is a controlling interest. (e) Any person, as required by authorizing statutes, seeking employment with a licensee or provider who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, ... with a licensee or provider whose responsibilities require him or her to provide personal care or personal services directly to clients, or ... with a licensee or provider to work 20 hours a week or more who will have access to client funds, personal property, or living areas. Evidence of contractor screening may be retained by the contractor's employer or the licensee. (3) All ... must be provided in electronic format. Screening results shall be reviewed by the agency with respect to the offenses specified in s. 435.04 and this section, and the qualifying or disqualifying status of the person named in the request shall be maintained in a database. The qualifying or disqualifying status of the person named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee's behalf. (4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an ... awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of	CZ815		

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CZ815	Continued From page 60 another jurisdiction: (a) Any authorizing statutes, if the offense was a felony. (b) This chapter, if the offense was a felony. (c) Section 409.920, relating to Medicaid provider fraud. (d) Section 409.9201, relating to Medicaid fraud. (e) Section 741.28, relating to domestic violence. (f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection. (g) Section 784.03, relating to battery, if the victim is a [redacted] adult as defined in s. 415.102 or a patient or resident of a facility licensed under chapter 395, chapter 400, or chapter 429. (h) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems. (i) Section 817.234, relating to false and fraudulent insurance claims. (j) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony. (k) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider. (l) Section 817.505, relating to patient brokering. (m) Section 817.568, relating to criminal use of personal identification information. (n) Section 817.60, relating to obtaining a credit card through fraudulent means. (o) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony. (p) Section 831.01, relating to forgery. (q) Section 831.02, relating to uttering forged instruments. (r) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes. (s) Section 831.09, relating to uttering forged	CZ815		

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CZ815	Continued From page 61 bank bills, checks, drafts, or promissory notes. (t) Section 831.30, relating to fraud in obtaining medicinal drugs. (u) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony. (v) Section 895.03, relating to racketeering and collection of unlawful debts. (w) Section 896.101, relating to the Florida Money Laundering Act. If, upon rescreening, a person who is currently employed or with a licensee and was screened and qualified under s. 435.04 has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency no later than 30 days after receipt of the rescreening results by the person. (5) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening. (6)(a) As provided in chapter 435, the agency	CZ815		

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CZ815	Continued From page 62 may grant an exemption from disqualification to a person who is subject to this section and who: 1. Does not have an active professional license or certification from the Department of Health; or 2. Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification. (b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may grant an exemption from disqualification to a person who is subject to this section and who has received a professional license or certification from the Department of Health or a regulatory board within that department and that person is providing a service within the scope of his or her licensed or certified practice. (7) The agency and the Department of Health may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, chapter 435, and authorizing statutes requiring background screening and to implement and adopt criteria relating to retaining [illegible] pursuant to s. 943.05(2). (8) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this section, terminates the person against whom the report was issued, whether or not that person has filed for an exemption with the Department of Health or the agency. 435.06 Exclusion from employment.- (1) If an employer or agency has reasonable	CZ815		

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CZ815	Continued From page 63 cause to believe that grounds exist for the denial or termination of employment of any employee as a result of background screening, it shall notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity. (2)(a) An employer may not hire, select, or otherwise allow an employee to have contact with any person that would place the employee in a role that requires background screening until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of employment. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select, or otherwise allow the employee to have contact with any person that would place the employee in a role that requires background screening unless the employee is granted an exemption for the disqualification by the agency as provided under s. 435.07. (b) If an employer becomes aware that an employee has been for a disqualifying offense, the employer must remove the employee from contact with any person that places the employee in a role that requires background screening until the is resolved in a way that the employer determines that the employee is still eligible for employment under this chapter. (c) The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of this chapter or place the employee in a position	CZ815		

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CZ815	Continued From page 64 for which background screening is not required unless the employee is granted an exemption from disqualification pursuant to s. 435.07. (d) An employer may hire an employee to a position that requires background screening before the employee completes the screening process for training and orientation purposes. However, the employee may not have direct contact with persons until the screening process is completed and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment. (3) Any employee who refuses to cooperate in such screening or refuses to timely submit the information necessary to complete the screening, including , if required, must be disqualified for employment in such position or, if employed, must be dismissed. (4) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages against, an employer that, upon notice of a conviction or for a disqualifying offense listed under this chapter, terminates the person against whom the report was issued or who was , regardless of whether or not that person has filed for an exemption pursuant to this chapter. 435.02 Definitions.-For the purposes of this chapter, the term: (2) "Employee" means any person required by law to be screened pursuant to this chapter, including, but not limited to, persons who are contractors, licensees, or volunteers. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that employees had an eligible level 2 background screening prior to working	CZ815		

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CZ815	Continued From page 65 with residents for one employee (Staff D) of six sampled employees. Findings Included: An employee record review for Staff D, conducted on [redacted], revealed that Staff D's employee record did not contain evidence of an eligible level-2 background screening. Staff D's employee record did not contain the employee's date of hire. During an interview with the Fiscal Agent, conducted on at 02:35pm, the Fiscal Agent stated that Staff D's record did not include an eligible level 2 background screening. Unclassified	CZ815		
CZ816	408.809(2) 435.05(2) 59A-35.090(2d-3b) Background Screening-Compliance Attestation 408.809 Background screening; prohibited offenses.- (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's [redacted] to the Federal Bureau of Investigation for a national criminal history record check unless the person's [redacted] are enrolled in the Federal Bureau of Investigation's national retained print [redacted] notification program. If the [redacted] of	CZ816		

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CZ816	Continued From page 66 such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit [redacted] electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the [redacted] to the Federal Bureau of Investigation for a national criminal history record check. The [redacted] shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person [redacted]. The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that: (a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section; (b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and (c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency. 435.05 Requirements for covered employees and	CZ816		

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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
CZ816	Continued From page 67 employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers: (2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if for any of the disqualifying offenses while employed by the employer. 59A-35.090 Background Screening. (2) Processing Screening Requests, Required Documents and Fees. (d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, , herein incorporated by reference, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-09106, and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Regulations_Forms.shtml. This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if for any disqualifying offense. (e) An administrator or chief financial officer must be screened and qualified prior to to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered	CZ816		

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	AL11953318	A. BUILDING: _____ B. WING _____	C 03/01/2023

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CZ816	Continued From page 68 with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the report and court disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to Section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with Section 435.06(3), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain a signed Affidavit of Compliance with Background Screening Requirements for six employees (Administrator, Fiscal Agent, and Staff A, B, C, and D) of six sampled employees. Findings Included: A record review for the Administrator, Fiscal Agent, and Staff A, B, C, and D, conducted on ., revealed that the Administrator, Fiscal Agent, and Staff A, B, C, and D's employee records did not have an Affidavit of Compliance with Background Screening Requirements signed by the employees. The Administrator, Fiscal Agent, and Staff A were hired on . Staff B was hired on . Staff C was hired on . Staff D's date of hire was not noted in the employee's record. During an interview with the Fiscal Agent, conducted on at 02:35pm, the Fiscal	CZ816		

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CZ816	Continued From page 69 Agent was unable to provided signed Affidavit of Compliance for the Administrator, Fiscal Agent, and Staff A, B, C, and D. Unclassified	CZ816		
CZ830 SS=D	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 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	CZ830		

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CZ830	Continued From page 70	CZ830		

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 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

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CZ830	Continued From page 71 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 their comprehensive emergency management plan (CEMP) annually for approval. Findings Included: A review of the most recent CEMP approval document, conducted on , revealed that the approved CEMP document provided was dated . There were no other submissions or approvals provided. During an interview with the Fiscal Agent, conducted on at 11:18am, the Fiscal Agent stated that there was an issue with uploading the documents to the electronic system and that the CEMP had not been submitted. Later 01:45pm, the Fiscal Agent confirmed that the facility's CEMP had not been submitted for approval. Class III	CZ830		
CZ841 SS=D	408.823( ) FS In-person Visitation	CZ841		

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CZ841	Continued From page 72 (1) This section applies to [redacted] centers as defined in s. 393.063, hospitals licensed under chapter 395, nursing home facilities licensed under part II of chapter 400, hospice facilities licensed under part of chapter 400, intermediate care facilities for the [redacted] licensed and certified under part VIII of chapter 400, and assisted living facilities licensed under part I of chapter 429. (2)(a) No later than 30 days after the effective date of this act, each provider shall establish visitation policies and procedures. The policies and procedures must, at a minimum, include [redacted] control and education policies for visitors; screening, personal protective equipment, and other [redacted] control protocols for visitors; permissible length of visits and numbers of visitors, which must meet or exceed the standards in ss. 400.022(1)(b) and 429.28(1)(d), as applicable; and designation of a person responsible for ensuring that staff adhere to the policies and procedures. Safety-related policies and procedures may not be more stringent than those established for the provider's staff and may not require visitors to submit proof of any [redacted] or immunization. The policies and procedures must allow consensual physical contact between a resident, client, or patient and the visitor. (b) A resident, client, or patient may designate a visitor who is a family member, friend, guardian, or other individual as an essential caregiver. The provider must allow in-person visitation by the essential caregiver for at least 2 hours daily in addition to any other visitation authorized by the provider. This section does not require an essential caregiver to provide necessary care to a resident, client, or patient of a provider, and	CZ841		

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CZ841	Continued From page 73 providers may not require an essential caregiver to provide such care. (c) The visitation policies and procedures required by this section must allow in-person visitation in all of the following circumstances, unless the resident, client, or patient objects: 1. End-of-life situations. 2. A resident, client, or patient who was living with family before being admitted to the provider ' s care is struggling with the change in environment and lack of in-person family support. 3. The resident, client, or patient is making one or more major medical decisions. 4. A resident, client, or patient is experiencing emotional distress or grieving the loss of a friend or family member who recently . 5. A resident, client, or patient needs cueing or encouragement to eat or drink which was previously provided by a family member or caregiver. 6. A resident, client, or patient who used to talk and interact with others is seldom speaking. 7. For hospitals, childbirth, including labor and delivery. 8. . . . . patients. (d) The policies and procedures may require a visitor to agree in writing to follow the provider's policies and procedures. A provider may suspend in-person visitation of a specific visitor if the visitor violates the provider's policies and procedures. (e) The providers shall provide their visitation policies and procedures to the agency when applying for initial licensure, licensure renewal, or change of ownership. The provider must make the visitation policies and procedures available to the agency for review at any time, upon request. (f) Within 24 hours after establishing the policies and procedures required under this section,	CZ841		

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CZ841	Continued From page 74 providers must make such policies and procedures easily accessible from the homepage of their websites. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have a visitation policy and procedures within thirty days of . . . . . Furthermore, the facility failed to have a visitation policy and procedures posted on the facility website. Findings Included: A review of the facility ' s website conducted on , revealed that the website did not include a visitation policy and procedures. During an attempt to review the facility visitation policy and procedures, conducted , there was no visitation policy and procedures available for review. During an interview with the Fiscal Agent, conducted on . . . . . at 12:43pm, the Fiscal Agent stated that the facility did not have a written visitation policy and procedures and agreed that there was no visitation policy and procedures posted to the facility's website. Class III	CZ841		