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
	AL11911636	A. BUILDING: _____ B. WING _____	03/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INN AT CYPRESS VILLAGE, THE	4600 MIDDLETON PARK CIRCLE, E. JACKSONVILLE, FL 32224

(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
CZ830	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider	CZ830		

AHCA Form 3020-0001

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

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CZ830	Continued From page 1 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 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	CZ830		

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CZ830	Continued From page 2 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 interview and record review, the facility failed to submit Comprehensive Emergency Management Plan (CEMP) revisions to the emergency management agency within 30 days of receiving a request. This has potential to affect all residents of the facility in the event the CEMP is utilized in an emergency. The findings include: Review of the facility's CEMP revealed that the last approval was . . Photographic evidence obtained. In an interview with the Administrator at . . . . at 10:00 am, she stated that she had resubmitted the plan and was asked later to submit the plan again in a different format. She confirmed that she had not submitted the requested information to the local emergency management officials within 30 days of the request. She contined to explain that she had been in communication with the local emergency management authority regarding her issues and provided copies of email communications. Review of the email correspondance dated . . . . . indicated that the facility had not submitted the requested information that was requested on . The email further indicated that due this delay, the fire safety inspection was out of compliance and would also need to be updated for the CEMP. An email dated to the emergency management authority indicated the	CZ830		

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CZ830	Continued From page 3 facility was working on the requested revisions. Photographic evidence obtained. On at 8:50 am, a represenative for the local emergency management authority confirmed she was still waiting for revisions from the facility. They originally submitted the CEMP on and she emailed asking for revisions on . On she left a voicemail and followed up with the email exchange(above) on . She confirmed it had been over 30 days since she requested the revision to the CEMP and she had yet to recieve what was needed for CEMP approval. Class III	CZ830		

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A 000	Initial Comments A relicensure survey in conjunction with complaints #2022014347, 2022018821 and 2022004935 was conducted at The Inn at Cypress Village from [redacted]. The facility had deficiencies identified at the time of survey.	A 000		
A 008	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	A 008		

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A 008	Continued From page 1 facility's record of the resident and must be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or [illegible] 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	A 008		

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A 008	Continued From page 2 her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of [illegible] require such assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a [illegible]-to-[illegible] 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,	A 008		

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A 008	Continued From page 3 7. A statement on the day of the examination that, in the opinion of the examining health care practitioner, the individual's needs can be met in an assisted living facility; and, 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care practitioner. (b) When a health care practitioner conducts a medical examination, the examination must be recorded on the practitioner's form or on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, , , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No =Ref-13531. Faxed or electronic copies of the completed form are acceptable. If AHCA Form 1823 is used, the form must be completed as instructed. 1. If the health care practitioner's form does not include all the examination items on AHCA Form 1823 or if AHCA Form 1823 is not completed fully, then the omitted items may be obtained by the administrator or designee either orally or in writing from the health care practitioner. The missing or omitted information must be obtained and documented in the resident's record within 30 days after the resident's admission to the facility. 2. Omitted or missing information received orally must include the name of the health care practitioner, the name and signature of the administrator or designee recording the information, and the date the information was provided. (c) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded	A 008		

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

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A 008	Continued From page 5 Clinical record for Resident #10 indicated he was admitted to the facility . . . . . Resident #10's AHCA Form 1823 contained sections that had not been completed. His elopement risk status, nursing /treatment/ , , requirements, and an assessment on whether the needs of the resident could be met in an assisted living facility were all unanswered. The form was dated . . . . . , Photographic evidence obtained. In an interview with the Administrator on at 12:00 pm she confirmed that the AHCA form 1823 for Resident #10 was incomplete and facility had not obtained and updated form. Class III	A 008		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or . , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making . , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the	A 025		

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A 025	Continued From page 6 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 changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to make arrangements for	A 025		

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A 025	Continued From page 7 physician's ordered diagnostic lab work for 1 of 4 residents whose records were reviewed (Resident #1), and failed to notify the physician and implement interventions following significant [illegible] loss for 1 of 4 residents reviewed (Resident #1). The findings include: In a telephone interview with a family member of Resident #1 at 10:45 am on [illegible], it was reported that Resident #1 had [illegible]. The diagnosis was caused by elevated ammonia levels in her [illegible]. A record review for Resident #1 found she was admitted to the facility on [illegible]. She had an AHCA form 1823, Resident Health Assessment, dated [illegible] that noted diagnoses including, but not limited to, [illegible] and [illegible]. Special precautions included memory care and hospice services. Resident #1 required assistance with all activities of daily living and with medication management. Photographic evidence obtained. Resident #1's [illegible] were reviewed and revealed on [illegible] she [illegible]. On [illegible] Resident #1 [illegible]. By [illegible], Resident #1 had loss [illegible] and [illegible]. This reflected a loss of 19.5% of her total body [illegible]. On [illegible], Resident #1 [illegible]; an additional loss of [illegible] in a month and a half, or 8.75% of her body [illegible]. A review of Resident #1's clinical records found there was no indication the physician was advised of Resident #1's [illegible] loss on either occasion,	A 025		

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A 025	Continued From page 8 nor was there evidence of any nutritional interventions to address, counter or prevent further loss. Resident #1's record included a Physician's Assistant (PA) progress note dated that reported recent (related to a). The recommendation was to monitor the resident closely for acute versus mental changes. Resident #1 was described as being more reserved since the and not . A and ammonia levels (lab work) were ordered, and the signed order placed in the record on . Photographic evidence obtained. A was performed on , as ordered, however there were no ammonia level results in Resident #1's clinical record. An interview was conducted with the Health and Wellness Director (HWD) at 10:00 am on . She was asked for the ammonia level results at this time. She stated she would attempt to locate them, but did not return with any results. An interview was conducted with the HWD on at 4:37 pm. She stated when a resident has loss the nurse highlights the and ensures it was obtained correctly. If there is loss, the Physician is notified. Sometimes he will change medications, for instance, manipulate . She was shown Resident #1's history and advised there were no apparent interventions implemented. In an interview with the Administrator in the presence of the HWD on at 2:30 pm, she was advised of, and acknowledged, Resident #1's loss. The HWD acknowledged that the	A 025		

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A 025	Continued From page 9 loss was significant. The Administrator was adsvised there was no evidence that Resident #1's physician or family was notified, and that no nutritional interventions were put in place. Neither had an explanation why. The HWD reviewed the signed order for ammonia levels dated . She stated she had called the lab but there was no record the levels were ever obtained. She had no explanation why the labs level was not obtained or why the Physician or PA failed to recognize the labs were never drawn. Class III	A 025		
A 030	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the	A 030		

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A 030	Continued From page 10 Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the	A 030		

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A 030	Continued From page 11 resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . . . and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from	A 030		

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A 030	Continued From page 12 community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making . . . . . for health care services, the provision of or arrangement of transportation to health care . . . . . , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated	A 030		

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A 030	Continued From page 13 mentally , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State	A 030		

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A 030	Continued From page 14 Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the right to	A 030		

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A 030	Continued From page 15 a safe living environment by minimizing the risk of injury from for 1 of 2 residents sampled for precautions. The findings include: A telephone interview was conducted with a family member of Resident #1 on at 10:45 am, who reported Resident #1 had multiple while in the facility, and a history of prior to admission. Some of the resulted in injuries. The facility had her purchase a mat for Resident #1, since they could not use side rails or seatbelts. A record review for Resident #1 found she was admitted to the facility on . She had an AHCA form 1823 assessment dated that noted diagnoses including, but not limited to, , and . She had limited mobility and was alert with . Resident #1 required assistance with transfers and ambulation. Photographic evidenceo btained. A Risk Evaluation dated noted Resident #1 had 10 non-injury in the last 12 months and 2 resulting in injury. Resident #1 sometimes gets out of bed or her chair without staff assistance. Review of electronic progress notes, Physician's Reports, and Post Evaluations revealed that since the evaluation, Resident #1 had 6 more ; one of the ( ) resulted in a to her forehead, transport to the emergency room and . The most recent on resulted in a bump to her forehead. On at 9:10 am, Resident #1 was	A 030		

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A 030	Continued From page 16	A 030		

observed in her room. She was in bed and appeared to be asleep. Her bed was in a low position but there was no mat on the floor beside the bed.

An interview was conducted with the Health and Wellness Director (HWD) on at 10:20 am. She was asked what precautions the facility used for residents identified as at risk for . The HWD stated the the facility did not use side rails, chair or bed alarms, as those were considered . On admission, they ask about the new resident's history. The majority of residents do have a history. High risk residents are encouraged to stay out of their rooms and stay involved. Staff escort residents who are risks to activities and meals, are trained in transfers and how to assist residents to the floor if they start to . A risk assessment is completed on admission, every 6 months and with any change in condition. All apartments have a pull cord system to alert staff, but not every resident has a wearable pendant. Usually the residents in memory care don't have pendants as they lose them and do not know how to use the device. Resident #1 has had . She is in a high wheelchair and will scoot herself down in the chair. Resident #1 also leans forward but they cannot restrain her. The staff round every hour or so, but a minimum of every two hours. precautions include a low bed when in bed.

In a brief interview with Employee E, Medication Technician, on at 3:00 pm, she was asked how often staff check on residents in the MCU. She stated every two hours. When asked what precautions were in place for Resident #1, she said, "I have never heard of her falling."

On at 3:05 pm, Resident #1 was again

Agency for Health Care Administration

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A 030	Continued From page 17 observed in bed. The bed was low but there were no mats in place. Employee A, the MCU Licensed Practical Nurse (LPN), was interviewed on at 3:07 pm. She stated residents are to be checked at least every two hours. Resident #1 was at risk for and interventions included a low bed and her mat down. Resident #1 sometimes tried to self-transfer. She stated there were no written directives for the use of her floor mat; it is "just known" that it is to be in place. Upon observation of the resident's room during the interview, a caregiver was just leaving Resident #1's bedside. The aid departed the room without putting down a floor mat. Employee A looked under the resident's bed and located a folded floor mat. She retrieved and unfolded the mat, placed it next to the bed, and lowered the bed to it's lowest position. Employee A was advised of the earlier observation of Resident #1 with no mat in place. On at 11:50 am, Resident # was observed in her room. She was sitting in recliner chair under a blanket. There was no mat in place next to the chair. In an interview with the Administrator on at 3:15 pm, she stated if family provided a mat for a resident, she would expect it to be used. he was told of the observations throughout the survey. The Administrator had no explanation as to why staff were not placing the mat, but said her expectation was that would be used. Class III	A 030		

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A 052	Continued From page 18	A 052		
A 052	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit	A 052		

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A 052	Continued From page 19 dose of [illegible] solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the [illegible]. (4) Assistance with self-administration of medication does not include: (a) Mixing, [illegible], converting, or [illegible] medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a [illegible] of the body. (d) Administration of [illegible] preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with [illegible], or [illegible] preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003.	A 052		

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A 052	Continued From page 20 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility,	A 052		

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A 052	Continued From page 21 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure appropriate assistance with medication self-administration by for 3 of 5 residents (Resident #10, #11, and #13). The findings include: During an observation of Employee F, Medication Technician, assisting with medications for Resident #10, on [redacted] at 4:07 pm, he reviewed the electronic Medication Observation Record (eMOR) and obtained 3 halves of 25-100 milligrams (mg) medication from	A 052		

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A 052	Continued From page 22 the medication cart. The cart was parked in the dining area. He crushed the medication and missed it in apple sauce, and proceeded to the resident's room and spoon fed medication to the resident without informing the resident of what the medications were. In another observation on at 4:20 pm, Employee F, Medication Technician, was observed preparing medications for Resident #11. He reviewed the eMOR and obtained one tablet of 8mg and two tablets of 25-100mg from the medication cart that was parked in the dining area. He took the medication in the medication cup to the resident room. Resident #11 was spoon fed the medication with apple sauce without being informed of what the medications were. In an interview on at 4:25 pm, Resident #11 was asked what medication she had taken, she said, "I am not sure." On at 4:32 pm, Employee F continued to prepare medication for Resident #13. He obtained one tablet of 5 mg, Ketotif Drops 0.025%, inhaler, and half a tablet of 50mg. He put the medications in a medicine cup and proceeded to the resident's room. He donned gloves, instilled Ketotif Drops 0.025% one drop on each, and with the same gloves on he puffed inhaler into the resident's twice, then obtained the tablets and placed them on the resident's . Review of the medication label revealed 5 mg, one tablet at1800 bedtime, Ketotif Drops 0.025% one drop on each at bed time.	A 052		

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	AL11911636	A. BUILDING: _____ B. WING _____	03/22/2023

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A 052	Continued From page 23 Review of the medication patient package insert for , showed the "how to use" section read, "to prevent dry , hoarseness, and oral yeast from developing, gargle, rinse your with water and spit out after each use". In an interview on at 5:08 pm, Employee H, Registered Nurse (RN), he stated that the medication is prepared in the dining area and taken to the resident's room. Some residents can take their own meds and some cannot, therefore it was ok for the medication technicians to spoon feed them. When asked if there was any resident with medication waivers, for residents not to be informed of their medications, he said "no". In , interview with Employee E and F on at 5:05 pm, the both confirmed that some resident can not take their medications and therefore they have to spoon feed them. On at 11:50 am , Employee H, RN was observed preparing medication for Resident #13 . When asked what time the medications were due, he stated that the they were due at 9:00. When asked the medication administration times he stated that it was one hour before and one hour after, he confirmed that the medications were late because he was getting so distracted. When asked what happens when medication are late, he state that the physician should be notified. He confirmed that he had not notified the physician. In an interview on at 12:10 pm, the Health and Wellness Director was notified of the medication concerns. She confirmed staff needed re-education.	A 052		

Agency for Health Care Administration

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A 052	Continued From page 24 Reviewed of the facility policy and procedure titled Medication Administration (NUR021PP). The policy read , " to accurately prepare , administer and document all medications administration. The procedure indicated that all residents will be assessed for safe self administration if assessed to be unsafe, all medications will be administered as prescribed by the resident's physician/ Healthcare Provide Provider and only by persons lawfully authorized to do so. The following procedures should be followed for medication administration for and non- medications: 1. Providing assistance with solid doses of oral medication (page 1) a. Wash b. Prepare any necessary items c. Obtain medication observation record d. Obtain medication from the storage e. Verify the medication label with the MOR/EMAR f. Take the medication to the president and tell them the medications your are providing. Open the container in the presence of the resident. 7. Assistance with or (Page 3) Some residents may need assistance with , or . Allow each resident to do as much as possible for him or herself. NOTE: it is the policy and procedure for Life Care Services that all LPN's and RN's administer Class III	A 052		
A 056	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS.	A 056		

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A 056	Continued From page 25 (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the	A 056		

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A 056	Continued From page 26 resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care	A 056		

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A 056	Continued From page 27 provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure medications were readily available for 1 of 5 residents sampled (Resident #9) The findings include: In an interview on at 5:08 pm, Employee H, Registered Nurse (RN) was asked the process of reordering medications, he stated that the medication Technician should reorder the medication when they have at least three days' worth of medication left. He added that the medication card is also color coded when the medication should be re-ordered. An observation was conducted on at 5:00 pm of Employee E, Medication Technician, preparing medications for Resident #9 . After reviewing the eMOR, she obtained two tablets of , 500mg, one tablet of , 15 mg, one tablet of , 50mg, and one tablet of 20mg. She stated that Pradaxta 75mg was not available. She crushed the medications and mixed with apple sauce. She proceeded to the resident's room and spoon fed the medications to the resident. Review of the eMOR for Resident #9 revealed that she had missed Pradaxa from . 0n at 1:30 pm, Employee I, Medication Technician, was asked if she gave the Pradaxa	A 056		

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A 056	Continued From page 28 for Resident #9. She reviewed the eMOR and stated that she gave the medication. When asked to provide the medication, she opened the cart confirmed that it was not available in the cart. She added that she might have clicked that she gave it by mistake. Another search for the medication was conducted by Employee A, Licensed Practical Nurse (LPN), who confirmed the medication was not there. She reviewed the eMOR and confirmed that the medication had been unavailable since . . . . . . In an interview on . . . . . at 12:10 pm, the Health and Wellness Director was notified of the medication concerns. She confirmed education was needed for all staff. Class III	A 056		
A 078	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . . . . . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative . . . . . examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of	A 078		

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A 078	Continued From page 29 . . . . . testing materials satisfies the annual . . examination requirement. An individual with a positive . . . . . test must submit a health care provider's statement that the individual does not constitute a risk of . . . 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . . . . . . (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 _ 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	A 078		

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A 078	Continued From page 30 to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on a review of personnel records and interview with staff, the facility failed to obtain a written statement from a health care provider within 30 days of hire indicating employees did not have any signs or symptoms of communicable , for 3 of 5 employees whose files were reviewed (Employees C, D and E). The findings include: A personnel file for Employee B found she was hired as a Medication Technician on . The file contained an "Employee Consent & Record" that included 2 separate ( ) test results dated and ; however, the "Statement Free of " section was not completed. Neither the "Yes" no "No" box was marked. Photographic evidence obtained. A personnel file for Employee C found she was hired as a Medication Technician on . The "Employee Consent & Record" included ( ) test results dated and . The form was signed by a health care provider on ; however, the "Statement Free of " section was not completed. Both boxes were left unchecked. Photographic evidence obtained. A personnel file for Employee D found she was	A 078		

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A 078	Continued From page 31 hired as a Medication Technician on . . . . . The "Employee Consent & Record" included . . . . . (.) test results dated and . The form was signed by a health care provider on . . . . . ; however, the "Statement Free of " section was not completed and both boxes were left unchecked. Photographic evidence obtained. An interview was conducted with the Human Resources (HR) Manager at 11:20 am on . She reviewed the forms and confirmed the examining practitioner was not completing the freedom from communicable statements. The HR Manager expressed awareness and understanding of the requirement Class III	A 078		
A 081	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by	A 081		

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A 081	Continued From page 32 agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in [illegible] control, including universal precautions and facility sanitation procedures, before providing personal	A 081		

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A 081	Continued From page 33 care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , , ... The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, 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.	A 081		

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A 081	Continued From page 34 (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on a review of personnel files and interview with staff, the facility failed to ensure personnel records contained the documentation required for the preservice orientation for 3 of 5 employee records reviewed (Employees B, C and D). The findings include: A personnel file for Employee B found she was hired as a Medication Technician on _____. Evidence of the following required preservice orientation was not located in the file. A personnel file for Employee C found she was hired as a Medication Technician on _____. Evidence of the following required preservice orientation was not located in the file. A personnel file for Employee D found she was hired as a Medication Technician on _____. Evidence of the following required preservice orientation was not located in the file.	A 081		

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A 081	Continued From page 35 An interview was conducted with the Human Resources (HR) Manager at 11:20 am on . . . . . The 2-hour pre-service orientation requirements were discussed with her. She said resident rights, the license type, and facility services are covered in the Corporate Compliance training. She acknowledged there was no evidence the employees were trained on the facility's license and services offered, and that a certificate of completion must be issued on completion and signed by the Administrator. Class	A 081		
A 090	59A-36.011(11) FAC Training - . . . . (11) . TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding . (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding . . within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on a review of personnel files and interview with staff, the facility failed to ensure staff received on hour of training on the facility's policies and procedures regarding . . . . . (. . .) within 30 days of	A 090		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 090	Continued From page 36 hire for 3 of 5 employees whose files were reviewed (Employees B, C and D). The findings include: A personnel file for Employee B found she was hired as a Medication Technician on . . . . . Employee C's file found she was hired as a Medication Technician on . . . . . Employee D's file found she was hired as a Medication Technician on . . . . . These personnel files contained no evidence these employees participated in training related to the facility's policies and procedures for . An interview was conducted with the Human Resources Manager at 11:20 am on . . . . . She acknowledged there was no training in any of the employees records, and that specific training to the facility policy, procedure and practices needed to be provided to all employees. Class III	A 090		
A 165	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911636	A. BUILDING: _____ B. WING _____	03/22/2023

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A 165	Continued From page 37 required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. [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.	A 165		

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A 165	Continued From page 38 (6) . . . . , neglect, or . , ... must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility	A 165		

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A 165	Continued From page 39 failed to initial an adverse incident report with the Agency related to an event for which a resident was sent to a unit providing a higher level of care, for 1 of 14 sampled residents. The findings include: Medical record review for Resident #10 revealed that he was admitted to the facility on with diagnoses of 's, , , ( ), , , (high ,) and , , (high). A progress note dated indicated that the evening med tech found that Resident #10 was out of ABH gel. Upon looking at the sheet, staff documented that the night med tech gave one milliliter (ml) of ABH gel, as ordered, leaving 8 ml for the morning med tech. The evening med tech, however, informed the writer that the morning med tech stated that resident was out of ABH gel . This writer reached out to the med tech and asked about ABH cream. The med tech stated, "I did it wrong, I gave the whole thing to him." (The remaining 8 ml.) The writer notified the unit manager of the overage and the physician assistant (PA) on call. The on-call PA stated to send the resident out via 911 for observation. Resident #10 was sent to the hospital for observation as a result of the med tech giving too much ABH gel on and returned to the facility the next day. Review of the sheet for Resident #10 revealed that on at 06:00 am, one ml was administered leaving a balance of 8ml. At 3:00 pm on the same day, one ml was administered, leaving a balance of zero. Photographic evidence obtained.	A 165		

Agency for Health Care Administration

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A 165	Continued From page 40 Further review of the facility incident report dated indicated that the med tech overlooked the proper dosage of resident's medication so the resident was given too much ABH gel. The predisposing factor was noted as," Med tech was agency and new to the community and residents." Photohrahic evidence obtained. In an , interview on at 4:20 pm , the Administrator and Health and Wellness Director (HWD) were asked how the facility identified if an incident was adverse. They stated that the facility protocol for identifying an adverse incident was to check what the facility failed to do, and the outcome. They both confirmed that the facility did not have an adverse incident to file since the last survey. When asked about any incident with Resident# 10, they stated that they were not aware it happened. The Administrator reviewed the progress note and stated that she would need some time to find out what happened since no one brought it to her attention. During a follow up interview at 2:05 pm, the Administrator confirmed that there was no investigation conducted regarding the incident and therefore an adverse incident report was not filed. Class III	A 165		