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
	AL11968965	A. BUILDING: _____ B. WING _____	C 05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE SENIOR LIVING AT HERITAGE MANOR	1908 E 131ST AVE TAMPA, FL 33612

(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 #2023004183) was conducted at Best Care Senior Living at Heritage Manor on . There were deficiencies identified at the time of the survey.	A 000		
A 034 SS=D	59A-36.007(9) ASSISTIVE DEVICES (9) ASSISTIVE DEVICES. Facilities are responsible for ensuring the safe usage of a resident's assistive devices. (a) The facility must have policies and procedures that include the requirements and methods for assessing the physical condition of assistive devices that may injure the resident and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device. (b) Documentation of each assistive device a resident uses must be included in the resident's record. (c) Direct care staff using assistive devices while rendering personal services to residents must know how to operate and utilize the equipment. (d) All assistive devices must be clean, in good repair, and free of hazards. (e) The facility must encourage and allow the resident to function with independence when using the assistive device. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to have policies and procedures to ensure the safe usage and condition of assistive devices for resident two (Residents #25 and #26) of two sampled residents that used assistive devices of a wheeled walker or wheelchair.	A 034		

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A 034	Continued From page 1 Findings Included: During an observation conducted on . . . . . at 12:20pm, Resident #25 was observed at lunch sitting in a wheelchair. A record review for Residents #25, conducted on . . . . . , revealed no documentation that Resident #25 required the use of a wheelchair as an assistive device. Resident #25 was admitted on . . . . . Resident #25's health assessment form dated . . . . . did not note that the resident required the use of an assistive device of a wheelchair and did not note any physical or sensory limitations. During an interview conducted on . . . . . at 12:56pm, the Resident Care Coordinator stated that Resident #26 had a walker. A record review for Residents #26, conducted on . . . . . , revealed no documentation that Resident #26 required the use of a walker as an assistive device. Resident #26 was admitted on . . . . . Resident #26's health assessment form dated . . . . . did not note that the resident required the use of an assistive device of a wheelchair and did not note any physical or sensory limitations. During an interview with the Administrator at 12:54pm, the Administrator stated that she did not have an assistive device policy for the facility yet. Class III	A 034		

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A 052	Continued From page 2	A 052		
A 052 SS=D	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 3 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 4 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 5 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 and interview, the facility failed to ensure proper assistance with self-administration of medications by not comparing medication labels to Medication Observation Records (MORs), not popping pills out of medication packs in front of residents, and not observing residents take and swallow their medications for three Residents (#2, #3, and #5) of three sampled resident that required assistance with self-administration of medication. Findings Included:	A 052		

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A 052	Continued From page 6 During a medication pass observation with Staff A for Residents #2, #3, and #5 conducted on . . . . . , Staff A did not compare Residents #2, #3, and #5 medication labels to their MORs. Staff A did not pop the pills from the medication packs in front of Residents #2, #3, and #5. Staff A did not observe Residents #2, #3, and #5 take and swallow their medications. Staff A assisted Resident #5 with the resident's prescribed medications , 100mcg and . . . . . , ... 5mg at 12:15pm. Staff A assisted Resident #3 with the resident's prescribed medication . . . , ... 100mg at 01:07pm. Staff A assisted Resident #5 with the resident's prescribed medications . . . , ... 333mg and 1 gram at 01:15pm. During an interview with the Administrator, conducted on . . . . . at 02:14pm, the Administrator stated that unlicensed Medication Technicians were supposed to follow their training for proper assistance with self-administration of medications. The Administrator stated that Medication Technicians were supposed to compare the medication label to the resident's MORs to detect discrepancies. The Administrator stated that Medication Technicians were supposed to pop pills from the medication packs in front of residents. The Administrator stated that Medication Technicians were supposed to watch residents take and swallow their medications. Class III	A 052		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep	A 054		

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A 054	Continued From page 7 either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known _ the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to immediately update Medication Observation Records (MORs) each time a medication was offered to three Residents (#2, #3, and #5) of three sampled residents that required assistance with self-administration of medications. Findings Included:	A 054		

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A 054	Continued From page 8 During a medication pass observation with Staff A for Residents #2, #3, and #5, conducted on from 12:15pm through 01:15pm, revealed Staff A did not immediately document the medications that she assisted Residents #2, #3, and #5 with on their MORs. Staff A did not open the electronic MORs during the medication pass observation. Staff A assisted Resident #5 with the resident's prescribed medications 100mcg and 5mg at 12:15pm. Staff A assisted Resident #3 with the resident's prescribed medication 100mg at 01:07pm. Staff A assisted Resident #2 with the resident's prescribed medications 333mg and 1 gram at 01:15pm. During an electronic MORs audit for Resident #5, conducted on , revealed that Resident #5's 100mcg and 5mg were documented as given to the resident at 11:47am which was before the medication pass observation at 12:15pm. All Resident #5's 08:00am medication were documented as given to the resident at 11:47am. During an electronic MORs audit for Resident #3, conducted on , revealed that Resident #3's 100mg was documented as given to the resident at 01:32pm which was well after the medication pass observation at 01:07pm. During an electronic MORs audit for Resident #2, conducted on , revealed that Resident #2's 333mg and 1 gram were documented as given to the resident at 12:52pm which was before the medication pass observation at 01:15pm. All Resident #5's 08:00am medication were documented as given	A 054		

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A 054	Continued From page 9 to the resident at 12:52pm. During an interview with the Administrator, conducted on at 02:14pm, the Administrator stated that unlicensed Medication Technicians were supposed to document the medications as given to the residents right after they give the medications to the residents. During an interview with the Resident Care Coordinator, conducted on at 02:30pm, the Resident Care Coordinator reviewed the electronic MORs timestamps for Residents #2, #3, and #5 and agreed that their medication were not documented as given at the time that the medications were given to the residents. Class III	A 054		
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	A 078		

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A 078	Continued From page 10 provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (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	A 078		

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A 078	Continued From page 11 position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff . . . . . by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain a one-time statement that the employee was free from communicable . . . from a health care provider within thirty days of employment for one employee (Staff C) of two sampled employees. Findings Included: A record review for Staff C, conducted on . . . . . , revealed that Staff C's employee record did not include a one-time statement from a health care provider that the employee was free from communicable . . . . . with thirty days of employment. Staff C was hired on . During an interview with the Administrator, conducted on . . . . . at 02:18pm, the Administrator agreed that Staff C's employee record did not contain a one-time statement from a health care provider that the employee was free from communicable . . . . . within thirty days of employment. Class III	A 078		
A 083 SS=D	59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND . . . . . (.). A staff member who	A 083		

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A 083	Continued From page 12 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 record review and interview, the facility failed to provide staff on each shift with training in ( ) and First Aid (FA). Findings Included: A record review for the Administrator, conducted on , revealed that the Administrator's and FA had expired on . A record review for Staff B, conducted on , revealed that Staff B did not have evidence of FA training in the employee's record. The training did not include evidence of skills or demonstration of the training (photographic evidence obtained). There was no	A 083		

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A 083	Continued From page 13 evidence that the training was accredited by the American Association. Staff B was hired on as the Food Service Manager, unlicensed Medication Technician, and Resident Aide. A record review for Staff C, conducted on , revealed that Staff C's and FA training dated did not include evidence of skills or demonstration of the training. Staff C was hired on as an unlicensed Medication Technician and Resident Aide. A record review for Staff D, conducted on , revealed that Staff D's and FA training dated did not include evidence of skills or demonstration of the training. Staff D's and FA expired on . Staff D was hired on as an unlicensed Medication Technician and Resident Aide. A record review for Staff E and F, conducted on , revealed that Staff E and F did not have evidence of and FA training in the employees' records. Staff E was hired on as a Resident Aid. Staff F was hired on as an unlicensed Medication Technician and Resident Aide. A review of the staffing schedule, conducted on , revealed that Staff C worked with Staff F on on the 07:00am through 03:00pm shift. Staff D worked with Staff E on on the 11:00pm through 07:00am shift. There was no other staff found on these shifts that had adequate and appropriate and FA training. During an interview with the Administrator, conducted on at 02:18pm, the	A 083		

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	AL11968965	A. BUILDING: _____ B. WING _____	C 05/15/2023

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A 083	Continued From page 14 Administrator agreed that her and FA training had expired. The Administrator was unable to provide evidence that Staff B, C, D, E, and F had and FA training that included a demonstration/skills test. The Administrator was unable to provide evidence that Staff B's training was accredited by the American Association. Class III	A 083		
A 160 SS=D	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. 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 ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission	A 160		

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A 160	Continued From page 15 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 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	A 160		

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A 160	Continued From page 16 license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.435, F.S., and rule Chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the 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) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.; (q) The facility's . . . . . prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.; (w) 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, which included former residents' dates of discharge, reasons for discharge, and places that they were discharged to for fourteen	A 160		

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A 160	Continued From page 17 Residents (#8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, and #21) that were discharged from the facility. Findings Included: A review for the admission and discharge log, conducted on , revealed that the admission and discharge log was not up-to-date and did not include former residents' dates of discharge, reasons for discharge, and places that the residents were discharged to for Residents #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, and #21. *Resident #8 was admitted on . *Resident #9 was admitted on . *Resident #10 was admitted on . *Resident #11 was admitted on . *Resident #12 was admitted on . *Resident #13 was admitted on . *Resident #14 was admitted on . *Resident #15 was admitted on . *Resident #16 was admitted . *Resident #17 was admitted on . *Resident #18 was admitted on . *Resident #19 was admitted on . *Resident #20 was admitted on . *Resident #21 was admitted on . A review of the current resident list, conducted on , revealed that Residents #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, and #21 were not listed as current residents. During an interview with the Administrator and Assistant Administrator, conducted on at 02:10pm, both agreed that the admission and discharge log was not up to date and did not include Residents #8, #9, #10, #11, #12, #13,	A 160		

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A	Continued From page 18 #14, #15, #16, #17, #18, #19, #20, and #21 dates of discharge, reasons for discharge, or places that the residents were discharged to. Class III	A 160		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. [illegible], 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance [illegible], 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, [illegible], or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in	A 162		

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A 162	Continued From page 19 paragraph 59A-36.007(1)(f), F.A.C. (f) A record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , ( ), CF-ES 1006,	A 162		

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A 162	Continued From page 20 2005, which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No =Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020,	A 162		

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A 162	Continued From page 21 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 failed to maintain a written record regarding changes in condition that resulted in the provision of additional services. one Resident (#25) of one sampled resident that had a required additional acute medical services. Findings Included: A record review for Resident #25, conducted on 05/015/2022, revealed that Resident #25 was admitted to the facility on . . . . . According to Resident #25's health assessment form dated . . . . . , the resident had a diagnosis of Generalized Major , , ... ( ), required supervision with ambulation, ... , and grooming and assistance with bathing. A rcored review conducted on revealed an incident report dated . . . . . , reportd that Resident#25 at 12:18pm and hit her . . . while using the bathroom. Resident #25's was and she was sent to the hospital. An observation report dated . . . . . stated that Resident #25 was sent to the facility and while a staff was fixing the residents bed, the resident appeared kind of shaky and on to the floor and hit the right side of her . . . . Resident #25 was then sent to the hospital. There was no documentation in Resident #25 related to the changes in condition or that sent the resident to the hospital twice on . . . . . There was no evidence of interventions that the facility put in place to prevent Resident #25 from having recurring . The resident was observed	A 162		

Agency for Health Care Administration

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A 162	Continued From page 22 sitting in a wheelchair at lunch and there was nothing noted on the resident's health assesment about special precautions or assistive devices. During an interview with the Resident Care Coordinator (RCC), conducted on . . . . . at 12:38pm, the RCC stated that Resident #25 had . . . . . on her arms because she kept falling. The RCC reported that the resident had on . . . . . and went to the hospital resulting in stitches on Resident # 25's and on her arm. When asked if this would be considered a change of condition, the RCC stated she would have to update the record. Class III	A 162		