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
	AL11965733	A. BUILDING: _____ B. WING _____	R 05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING AVENTURA	2777 NE 183rd ST AVENTURA, FL 33160

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A 165 SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or 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	A 165		

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A 165	Continued From page 1 preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional 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	A 165		

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A 165	Continued From page 2 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 interview and record review the facility failed to submit a one day incident report after three out of thirty two sample residents (Resident #32, #4, Resident #3) and they had to be transported to a higher level of care unit. The facility also failed to report . . . . . to residents to the Department of Children and Families (DCF) Findings as follow: 1. On at 3:45 PM Staff U interviewed about Resident #32's . . . . . , stated while she was on Memory Care unit observed a on resident's . . . . She stated the resident told her that one day (day not specified), she had while putting on her shoes, resident got herself up from the floor and went to her bedroom. Staff added resident didn't ask for any assistance or inform the staff. Review of Resident #32 observation notes showed on . . . . . Staff U reported resident was found lying on the bedroom floor, resident observed holding her . . . stating " " I hit my " big bumps noted to the upper of without any . . . . . . She was unable to explain what happened. 911 was called and	A 165		

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A 165	Continued From page 3 resident was transported to a local hospital for higher level of care. 2. On at 4:33 PM the son of Resident #3 stated through phone interview the Administrator told him that the facility failed to inform him about the incident when his mother was physically by another resident (Resident #8). He stated expressed the management staff that he was upset because he was not told what really happened to his mother and the facility Administrator told him that he would send him the incident report. A review of facility records found no documentation that the resident's violence toward the other resident was reported to DCF. Review of Resident #3's progress notes showed on Staff X reported resident after being pushed by Resident #8, resident hit her and complained of , 911 was called; the resident was assessed by them and transported to the emergency room at local hospital complaining of , . Review of hospital records showed on Resident #3 was admitted for an unwitnessed , left and after a ground level . 3. On At 2:4, Resident #4's daughter stated her mother had on and injured right spiral . She stated she was not given exact details of what happen however she was told that her mother was found on the floor during the overnight or earlier morning shift, and she was being hospitalized because they believed her , was broken. Review of Resident #4's progress notes documented on at 7:47 AM Staff F	A 165		

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A 165	Continued From page 4 called Staff W to the floor where the resident was seen lying on the floor next to her bed. When asked what happened, the resident stated "I went to answer the door and I ". On assessment Resident #4 was unable to move her right and complained of , when touched. 911 was call and resident was transferred to a local hospital for possible , . 4. Review of the Facility's Disciplinary Action form dated given to Staff I documented during the week of through , 'Staff I was observed as being unkind and disrespectful once again' and the following incidents were documented: -Staff I yelled in an aggressive manner "stop taking things that don't belong to you" when a resident removed a crossword puzzle from the activity table. -Staff I forcefully lifted a resident's onto the wheelchair rest and pushed him into the dining room. -Staff I gabbed a resident who was making sounds, placed her forcibly on the sofa and said " you need to stop making noise, you are disrupting everyone". -Staff I told a resident " go away and stop crying" when a resident approached her telling " please help me someone is going to kill me." On at 12:45 PM the Administrator stated he believed he only had to report preventable occurrences . Review of facility records and the incident report database revealed there was not documentation showing the facility submitted reports about incidents involving Residents #32, #3 and #4 and Staff I.	A 165		

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A 165	Continued From page 5 Class III	A 165		
{A 000}	Initial Comments A revisit to a Complaint Investigation (Complaint #2022017096) was conducted at Sterling Aventura from , , through , , . Deficiencies were identified at the time of the survey.	{A 000}		
A 010 SS=G	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices.	A 010		

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A 010	Continued From page 6 (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . . . . . . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been	A 010		

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A 010	Continued From page 7 placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services	A 010		

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A 010	Continued From page 8 license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A . . , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however,	A 010		

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A 010	Continued From page 9 staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, interviews, and review of records the facility failed to determine the continued appropriateness of continued residency of one out of 167 residents (Resident #8) The facility failed to manage Resident #8's aggressive and violent behavior towards other residents and staff. Findings Include: Observation on at 8:00 PM showed that Resident #8 appeared agitated inside her room. Further observation showed that Resident #8 exhibited aggressive behavior, pacing the room, and encroaching on another person's space while a Private Duty Aide (PDA) blocked the room door and attempted to redirect her. Interviewed on at 8:00 PM the PDA stated that she worked from 7:00 am to 11:00 pm and the facility staff was responsible for supervising Resident #8 when she was not present. Interviewed on Staff I stated that Resident #8 had always been aggressive with the staff and other residents since she was admitted to the facility. Staff I also stated that Resident #8 was prone to lash out on everyone, the staff, and other residents and that she was very "clingy". Staff I stated that she believed that Resident #8 had gotten worse because the facility had allowed her to the residents and staff. Staff I	A 010		

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A 010	Continued From page 10 stated, "She [redacted] anyone when she gets upset." Review of Resident #8's Health Assessment of [redacted] showed diagnoses of [redacted], Major [redacted] and [redacted]'s with early onset. Review of Resident #8's Progress Notes showed: "On [redacted] Resident #8 tried to hit Staff I. On [redacted] Resident #8 pushed Resident #3 to the ground causing her to hit her [redacted] on the floor. Resident #3 was taken to the hospital emergency room by paramedics via stretcher complaining of [redacted]. Further review showed that the facility staff observed Resident #8 agitated and aggressive at times, pushing, slamming doors, and grabbing at everything she could reach. On [redacted] Resident #8 grabbed Resident #2 by the [redacted] and [redacted], the facility staff intervened and prevented Resident #2 from falling to the ground. Further review showed that after the staff separated her from Resident #2 Resident #8 attempted to [redacted] other residents and local police and emergency services were called. On [redacted] Resident #8 was admitted to the hospital under the [redacted] with symptoms of agitation, aggressiveness, [redacted], and poor judgement." Review of Resident #8's hospital records of [redacted] showed: "[redacted] with behavioral disturbance, Acute on [redacted], [redacted], [redacted]. Referred from an ALF via AMS due to increased [redacted], not sleeping and aggressive and	A 010		

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A 010	Continued From page 11 violent behavior towards other residents at the facility." Review of Resident #8's hospital Discharge Summary of .. .. showed diagnoses of , and History of Present Illness stating: "Admitted under placed by the facility's nurse practitioner for . . . . , ..., and aggressive and violent behavior towards other residents, reports she even hurt another resident who ended up in the hospital as a result of the incident." Review of Resident #8's Progress Notes of showed that she returned from the hospital without major changes, remained , and paramedics had reported that Resident #8 exhibited agitation during transport. Further review showed that Resident #8 required constant supervision for behavior management and that her daughter was advised that a one-on-one private duty aide was required for safety. Review of Resident #3's Health Assessment of ..... showed diagnoses of ., and precautions. Resident #3 used an ambulatory device (Walker) Review of Resident #2's Health Assessment of showed diagnoses of 's ..... and . Class II	A 010		
{A 025} SS=H	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision	{A 025}		

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{A 025}	Continued From page 12 429.26 (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 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	{A 025}		

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{A 025}	Continued From page 13 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 interview and record review, the facility failed to provide adequate supervision as appropriate for each resident to ensure awareness of the general health, safety, physical and emotional well-being for four out of 39 sampled residents (Residents #3, #4, #29, #32). Resident #4 sustained a right [illegible], and Resident #29 suffered a bone [illegible] after a [illegible]. Resident #32 sustained a black [illegible], and [illegible] on the right side of her body, and Resident# 3 was transferred to the hospital after falling at the facility. Findings include: 1) A review of progress notes dated showed while trying to stand up to leave the dining room, Resident #3 lost her balance and [illegible]. The resident complained of [illegible] in the [illegible] of the [illegible]. 911 was contacted, and the resident was transferred to the hospital.	{A 025}		

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	AL11965733	A. BUILDING: _____ B. WING _____	R 05/24/2023

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{A 025}	Continued From page 14 A review of Resident #3's progress notes dated showed, "Resident was observed on the floor and awake. [Resident #8] was pacing in the hallway while [Resident#3] was heading to her room and pushed her down. Resident hit her and complained of . 911 was activated, and two officers showed up with paramedics after a complete assessment was done. They called the ambulance, and she was transported to [hospital] for further evaluation." In an interview with Resident #3's son on at 3 PM, he stated he was unaware that his mother had been in an incident with another resident and that the facility never notified him. He further noted that his mother had four times during the last two months. During an interview on at 8:05 PM, when asked about the incident with Resident #3, the Director of Nursing (DON) stated, "After she pushed [Resident #3], we got the psych doctor, we put one on one supervision on her, and the family hired a private duty aide." A review of the agency's adverse incident database showed Resident #3's and injury were not reported. A review of Resident #3's health assessment dated showed medical diagnoses and a history of and . The resident needed supervision with ambulation, eating, toileting, transferring and assistance with bathing, and grooming. The health assessment indicated that Resident #3 had precautions. A review of progress notes dated showed staff was notified that Resident #3 . When assisted from the floor, Resident #3 was	{A 025}		

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{A 025}	Continued From page 15 unable to bear [redacted] or move her left [redacted]. Staff called 911, and the resident was transferred to the hospital. A review of Resident #3's hospital records dated [redacted] showed a 'History of Present Illness' stating, "female comes in from her nursing facility secondary to an unwitnessed [redacted]. The patient reported left [redacted] and [redacted] after a ground-level [redacted]." A review of Resident #3's progress notes showed no documentation of physician recommendations to prevent the reoccurrence of [redacted]. There was no documentation of any interventions besides providing the resident a wheelchair after she on [redacted]. 2) A review of progress notes dated [redacted] showed the Medication Technician found Resident #4 on the floor, lying on her [redacted] in the kitchenette in her room. The resident could not explain how she [redacted] and complained of a [redacted]. 911 was called, and the resident was transported to the hospital. A review of Resident #4's progress notes dated [redacted] showed, "Certified Nursing Assistant (CNA) called the writer to the floor where the resident was seen laying on the floor next to her bed. On assessment, she was unable to move her right [redacted] and complained of [redacted] when touched. 911 was called, and the resident was admitted to [hospital] with a possible [redacted]." A review of Resident #4's health and service evaluation, last completed on [redacted], showed the resident had one to two [redacted] in the last 90 days and had a high potential for [redacted].	{A 025}		

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{A 025}	Continued From page 16 During an interview with Resident #4's daughter on at 2:45 PM, she stated, "My mother on and suffered a right spiral . Because of her advancement in her , she won't be able to recover and walk again. When I went to the hospital, she was screaming in . I was told they found her on the floor during the overnight or early morning shift. I've been trying to contact the facility for more information, but no one has answered my calls. This is not the first time she has and was injured. She in 2021 and broke her kneecaps." A review of Resident #4's health assessment dated showed medical diagnoses and a history of , , , , , and memory . The resident needed supervision with eating and assistance with ambulation, bathing, , grooming, toileting, and transferring. The health assessment indicated that the resident had no precautions. Further review of Resident #4's records showed no documentation of an updated health assessment after the resident . A review of Resident #4's record showed no documentation of any interventions or investigation into the resident's prior . There was no documentation that the physician was contacted for recommendations to prevent the reoccurrence of . 3) A review of Resident #29's progress notes dated showed, "During rounds, resident was noted lying on the floor on his left side. On examination, he had a hematoma on his left with moderate . Unable to explain	{A 025}		

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{A 025}	Continued From page 17 what happened. 911 was activated, and resident was transported to [hospital]." A review of Resident #29's hospital records dated showed a 'Physician note' stating, "male whose brought to the ER (emergency room) by (emergency medical services) from nursing home for with . Unclear the mechanism, the patient forward, striking his with noted around the left , . Differential diagnosis of and retrobulbar hematoma." A review of progress notes dated showed [Resident #29] was found lying on the floor with his "wrapped in his blanket". A review of progress notes dated showed Resident #29 was ambulating in the hallway when he lost his balance, , hitting his against the wall. The resident sustained a to the of his . The resident's wife refused for the resident to be transferred to the hospital but instead stated she would transport him herself. A review of Resident #29's progress notes dated showed as he was getting up, the resident lost his balance and on the floor. Staff noted a on his . A review of Resident #29's progress notes dated showed, "Resident was found sitting on the floor in his room fully clothed. Assessment completed with no visible injuries." A review of Resident #29's records showed he four times in . A review of progress notes dated	{A 025}		

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{A 025}	Continued From page 18 showed, "[Resident#29] this morning and was transported to [hospital] for of bone . Recommend making an , , for follow-up care with [doctor]." A review of Resident #29's hospital records dated showed a 'History of Present Illness' stating, "male with a past medical history of who presents after a . The patient was found down for an unknown period of time. Radiographic imaging results unremarkable, acute-on- . Cleaned up dry from patient's to evaluate small on the bridge." A review of the agency's adverse incident database showed Resident #29's and injury were not reported. Further review of Resident #29's progress notes showed no documentation that the physician was contacted for follow-up care. A review of Resident #29's progress notes dated showed at 12:45 AM, "Resident was observed sitting on the floor next to his bed, noted on/around his ." A review of Resident #29's progress notes dated showed, "call to 3rd floor to report that [Resident #29] was sitting in a wheelchair by the living room area and trying to stand up, lost his balance and found on his with a minor injury, some scrapes on the left cheek from his glasses." A review of Resident #29's health assessment dated showed medical diagnoses and a history of 's , , and sleep , . The resident needed	{A 025}		

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{A 025}	Continued From page 19	{A 025}		

assistance with ambulation, bathing, eating, self-care, toileting, and transferring. The health assessment also indicated that Resident #39 had precautions.

A review of Resident #29's record showed no documentation of any interventions or investigation into the resident's prior . There was no documentation that the physician was contacted for recommendations to prevent the reoccurrence of .

In an interview on at 1:10 PM, when asked about preventive measures the facility put in place to prevent Resident #29's , Resident #29's wife stated, "He was put on hospice in . No facility member has spoken to me about a care plan for [Resident #29]'s ."

4) A review of progress notes dated showed Resident #32 was found lying on the bedroom floor. Staff observed the resident holding her while stating, "I hit my ". Staff noted that the resident had "big bumps noted to the upper of the ." 911 was called, and the resident was transferred to the hospital.

A review of Resident #32's hospital record dated showed a 'History of Present Illness' stating ", female from ALF due to unwitnessed from bed, the patient found on the floor. The patient has left tissue without ."

On at 3:27 PM, observed Resident #32 with a black right and on the right side of her , and arm.

In an interview on at 3:34 PM, the

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{A 025}	Continued From page 20 Administrator stated he was unsure what happened to the resident's . On at 6:29 PM, when asked about her . . . , Resident #32 stated, "After I took a shower, I was trying to put on my clothes and shoes and . . After I . , I got myself up and went to bed. I didn't tell any of the staff I . None of them saw me . ." A review of Resident #32's progress notes showed no documentation that the physician was contacted for follow-up care. A review of Resident #32's health assessment dated showed medical diagnoses and a history of , , ... The resident needed assistance with ambulation, bathing, eating, self-care, toileting, and transferring. The health assessment also indicated that Resident #39 had . precautions. Further review of Resident #32's records showed no documentation of an updated health assessment after the resident . . A review of Resident #32's record showed no documentation of any interventions or investigation into the resident's prior . . other than asking the resident how she . There was no documentation that the physician was contacted for recommendations to prevent the reoccurrence of . . . Class II	{A 025}		
A 030 SS=H	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures	A 030		

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A 030	Continued From page 21 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to 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;	A 030		

Agency for Health Care Administration

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A 030	Continued From page 22 3. Medication storage; 4. Resident elopement; 5. Reporting resident . . . . ., neglect, and . . 6. Administrative and housekeeping schedules and requirements; 7. . . . . control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 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 030		

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A 030	Continued From page 23 (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (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	A 030		

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A 030	Continued From page 24 religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care . ,., ..., and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally . . ,. . . . . . . , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program 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	A 030		

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A 030	Continued From page 25 person without [illegible], 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, [illegible], 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 [illegible] Hotline operated by the Department of Children and Families, and, if applicable, [illegible], Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a 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 [illegible] Hotline operated by the Department of Children and Families, and [illegible], Rights Florida. 429.27 Property and personal affairs of residents.-	A 030		

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A 030	Continued From page 26 (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 [illegible] or [illegible] 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 interview and record review, the facility failed to ensure that five of 167 sampled residents (Residents #2, 3,12, 26,29) were free of [illegible] as well [illegible] by four direct care staff (Staff E, Staff I, Staff G and Staff O. Findings include: 1) A review of Staff E's personnel record dated [illegible] showed "On Friday evening, [illegible], it was reported that Certified Nursing Assistant [Staff E] placed a garbage bag under a resident to alleviate herself from her nightly duty of having to change his bedding during her shift as he suffers from regular [illegible]." In an interview on [illegible] at 6:50 PM with the	A 030		

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A 030	Continued From page 27 Director of Memory Care, he stated," [Resident #29]'s wife seen [Resident #26] in bed laying on top of a garbage bag. We identified it as [Staff E] because she was on the overnight shift providing care to [Resident #26]. We asked [Staff E] what happened, and she said that she didn't know, and it wasn't on her shift." When asked if other staff were interviewed, the Director of Memory Care stated, "Yes, we asked other staff, and everybody said no." Interviewed on at 12:07 PM, when asked about the incident with Resident #26, Staff E stated, "I wouldn't do that stupidness. I didn't even work that night." When asked about the disciplinary action she refused to sign, she replied, "He didn't say anything to me. I was never given any paper to sign. I overheard something about the garbage bags, and then [Memory Care Director] gave everybody a paper to sign saying no plastic bag to be used." On . . . . . at 1:10 PM, [Resident #29]'s wife stated, "One time I observed a garbage bag on top [Resident #26]'s bed. [Resident #26] was not in bed, but it upset me so much. I called the Memory Care Director, and he went to the room and observed it himself." A review of Resident #26's record showed no documentation of the incident or if the resident's family/ legal representatives were contacted. There was no documentation that Resident #26 was interviewed regarding the incident. In an interview on at 8:09 PM, the Administrator stated the incident was not reported to the Department of Children and Families. He further stated, "Anyone with common sense that they seen garbage bags used on residents would	A 030		

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A 030	Continued From page 28 report it." A review of the facility's resident . . . . . policy showed, "The Executive Director will review the facts of the investigation and determine what corrective action should be made, if any, to prevent a similar occurrence. The Executive Director shall inform the accused person(s) of the investigation findings, including any additional process involved. To protect the alleged victim (resident) from further . . . . . during the investigation, the accused person(s) shall be suspended pending internal investigation of the incident." A review of the facility's records showed no documentation of an investigation into the incident. There was no documentation of interviews with any witnesses and other staff on each shift. There was no documentation of any corrective action. There was no documentation of the Administrator speaking with Staff E about any investigation findings. In an interview with Staff E on . . . . . at 12:09 PM, she confirmed that she never met with the Administrator and that she has continued to work without any suspension. 2) In an interview with Resident #29's wife on . . . . . at 1:10 PM, she stated that one morning the resident's son observed his father in a soaked adult brief. In an interview on . . . . . at 6:50 PM, the Memory Care Director stated that a hospice nurse told Resident #29's wife, who then mentioned it to him. He further stated Staff O and Staff G were on shift together that day, and due to him not being able to distinguish which staff left	A 030		

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A 030	Continued From page 29 the resident unattended, they both were written up. When asked if other staff were interviewed about the incident, he stated, "No, Staff instead were informed of the situation and told to make sure it did not happen again." On . . . . . at 1:10 PM, when asked about the incident with Resident #29, Staff O stated, "I never heard about me leaving any resident in his diaper all night. It's not true I wouldn't do something like that. [Memory Care Director] never spoke to me about that and I didn't know I was written up for that." When asked why she signed the disciplinary notice, she stated that she was told it was for the training on how often staff were supposed to be changed. A review of Resident #29's record showed no documentation of the incident. There was no documentation of an investigation into the incident. A review of the facility records showed no documentation of an investigation into the incident. There was no documentation of any corrective action. There was no documentation of the Administrator speaking with Staff O or Staff G about any investigation findings. A review of Staff G and Staff O's personnel files showed both received disciplinary notices on due to "Residents were left unattended with no personal care provided. The resident was left in bed with feces and ." In an interview on at 6:54 PM, the Memory Care Director stated that both staff members continued to work at the facility without any suspension.	A 030		

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A 030	Continued From page 30 In an interview with the Memory Care Director on at 7:15 PM, when asked if the facility investigated whether this kind of . . . . . could happen on the other floors, he stated, "That is not my duty. I am only in charge of memory care. [Director of Health Services] is in charge of the care and the rest of the facility." 3) In an interview with the Administrator on at 4:36 PM, he stated, "[Staff I] that worked on the memory care floor was terminated a month ago due to performance issues." A review of Staff I's personnel files showed one written warning on . . . . . due to "[Staff I] has been observed as being unkind and disrespectful to several residents. Several residents have voiced concerns about being bullied by [Staff I], and families have reported that she is tough and lacks patience with residents." In an interview on at 10:27 AM, Staff I stated, "On . . . . . , management called me into the office and stated they observed me being rough to the residents. I never had these issues before. I had never been disciplined or investigated. They gave me a written warning. The next day on , I called the management's human resources and filed complaints against the Director of Activities and the other management staff for no investigation. I never received a response from them." When asked why she signed the disciplinary written warning, Staff I stated, "Management said if I didn't sign the form, I would be terminated." A review of the facility records showed no documentation of an investigation into the incidents involving Staff I. There was no documentation of any corrective action. There	A 030		

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A 030	Continued From page 31 was no documentation of interviews between the facility and the resident's family/ legal representatives. A review of Staff I's termination notice dated showed the reason listed as "On the week of through [Staff I] was observed as being unkind and disrespectful to a few residents once again." The notice details incidents from 27-29 of . On , Staff I yelled at a resident in an aggressive manner/tone. On , Staff I was observed forcefully lifting Resident #12's onto the wheelchair footrest while the resident yelled, "You are hurting me". On , Staff I was observed telling a resident, "Go away and stop crying", when she was approached for help. On at 10:33 AM, when asked about the residents she was accused of being rough with, Staff I stated she was only told about Resident #12. She further said, "On , they (Memory Care Director and Business Manager] brought me to the Administrator's office and told me I was observed picking up [Resident #12]'s roughly. [Memory Care Director] stated he watched me and said nothing until days later. No one brought any of the issues to me." During an interview on at 7:03 PM, when asked about the incidents involving Staff I, the Memory Care Director stated, "I observed her being rough with [Resident #12]; she took the resident's and put in the footrest and forcefully pushed him into the dining room. I spoke to her about it and told her that's not what we do to residents. There was a second incident where she grabbed a resident and put her on the other side of the room. When I spoke about it, she said the resident was disturbing her. Another	A 030		

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A 030	Continued From page 32 resident asked her for help because she believed she was going to get killed. [Staff I] ignored her and told her to go away." In an interview on at 12:45 PM, Resident #12's daughter stated she was not informed of any incidents concerning her father and any staff member. In an interview on at 10:33 AM, Staff I stated, "They never investigated the incidents. They didn't ask my other co-workers or the other residents or even come to me about any of the incidents. I never spoke to the Administrator." 3) Review of Resident #8's Health Assessment of showed diagnoses of , Major and 's with early onset. Review of Resident #8's Progress Notes showed: "On Resident #8 tried to hit Staff I. On Resident #8 pushed Resident #3 to the ground causing her to hit her on the floor. Resident #3 was taken to the hospital emergency room by paramedics via stretcher complaining of . Further review showed that the facility staff observed Resident #8 agitated and aggressive at times, pushing, slamming doors, and grabbing at everything she could reach. On Resident #8 grabbed Resident #2 by the and , the facility staff intervened and prevented Resident #2 from falling to the ground. Further review showed that after the staff separated her from Resident #2 Resident #8	A 030		

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A 030	Continued From page 33 attempted to . . . . other residents and local police and emergency services were called. A review of the facility's resident . . . . . policy showed, "The Executive Director will review the facts of the investigation and determine what corrective action should be made, if any, to prevent a similar occurrence. The Executive Director shall inform the accused person(s) of the investigation findings, including any additional process involved. To protect the alleged victim (resident) from further . . . . . during the investigation, the accused person(s) shall be suspended pending internal investigation of the incident." On at 7:15 PM, when asked about the investigation regarding Staff I, the Memory Care Director stated, "Me and the human resource manager held the meeting. We notified the Administrator of the results." Class II	A 030		
A 031 SS=E	59A-36.007(6) FAC Resident Care - Third Party Services (6) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, , and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to	A 031		

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A 031	Continued From page 34 coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the resident's needs. (c) The administrator or designee must ensure that: 1. Care coordination includes documented communications about the resident's condition and response to treatment or services ordered by the physician which may impact the resident's appropriateness for continued residency in the facility; 2. Communications occur at least once every 30 days and whenever there is a significant change in the resident's condition; and 3. If physician ordered treatments or services occur less often than once a month, communications must be conducted according to the ordered treatment or service schedule and whenever there is a significant change in the resident's condition. 4. When communication with the third party provider is unsuccessful, at least two attempts at communication on two separate days must be documented. Documentation must include the name of the person from the third party provider with whom contact was attempted, the method of communication, and the date and time of the attempts. This documentation must be included in the resident's record in accordance with the	A 031		

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A 031	Continued From page 35 timeframes in subparagraphs 59A-36.007(6)(c)2. and 3. (d) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure that home health records were available onsite for services provided to eight out of thirty-two (Resident #1, #14, #32,#34, #35, #36, #37, #38) sampled residents. Findings Included: A review of the facility's record showed there was no documentation of home health records on site. In an interview with the Director of Health Services on at 6:47 pm, she stated there were residents admitted to the facility utilizing home health services however she would have to request the records from the home health company. A review of home health company's records showed there were nine residents admitted to the facility who received home health services. - Resident #1 started home health services on - Resident #14 started home health services	A 031		

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A 031	Continued From page 36 on 04 /14/2023 - Resident#32 started home health services on . . . . . . - Resident #34 started home health services on . . . . . . - Resident #35 started home health services on . . . . . . - Resident #36 started home health services on . . . . . . - Resident #37 started home health services on . . . . . . - Resident #38 started home health services on . . . . . . Class III	A 031		
A 077 SS=D	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19.	A 077		

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A 077	Continued From page 37 Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least [illegible]; 2. If employed on or after [illegible], have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to [illegible], are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by	A 077		

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A 077	Continued From page 38 the agency or the department. (b) In the event of extenuating circumstances, such as the . . . . . of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile . . . . . of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , . . . , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except	A 077		

Agency for Health Care Administration

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A 077	Continued From page 39 as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No =Ref-09393. This Statute or Rule is not met as evidenced by: Based on observations, record review, and interview, the facility failed to have an administrator capable of handling the operation and maintenance of the facility, including the management of all staff and the residents. Findings Included: 1) On at 3:27 pm, observed the Administrator enter the 7th floor. In the hallway, he observed Resident #32 walking in the hallway. Resident #32 was observed to have numerous near her right , , right side of , and right arm. The Administrator asked the resident how and when the resident's occurred. In an interview with the Administrator on at 3:34pm, The Administrator stated he was not sure what happened to the resident's . He stated, " I don't know, I'm not too sure. I am just coming from a leave of absence". A review of the facility's roster showed the	A 077		

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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 077	Continued From page 40 Administrator was hired on . A review of Resident #32's progress notes showed on , the resident walked into the wellness center via walker. Discoloration observed to right , . The note stated ," She in the bathroom yesterday while putting on her shoes". There was no documentation of further examination of the occurrence. 2) A review of Resident #8's progress notes showed on , Resident #8 assaulted Resident#3. Resident #8 pushed Resident #3 to the ground causing her to hit and hit her on the ground. 911 was called and Resident #8 was transferred to hospital via stretcher. On another assulted occured, Resident#8 was observed assaulting Resident #2 by grabbing Resident#2's and . A review of Resident #8's hospital record showed on , Resident#8 was due to being aggressive and violent with residents and staff. On , Resident#8 returned to the facility. A review of the facility's resident policy and procedures showed in the event of resident , an initial investigation shall be immediately made by the department of Director of Health services (Charge nurse, supervisor, etc.) and findings shall be reported to the Executive Director (Administrator). The policy stated the residents' legal representative shall be notified within 24 hours of the alleged occurrences. Then, the Executive Director (Administrator) will review the facts of the investigation and determine what corrective action should be made, if any, to	A 077		

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	AL11965733	A. BUILDING: _____ B. WING _____	R 05/24/2023

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A 077	Continued From page 41 prevent to a similar occurrence. It also stated the Executive Director (Administrator) shall inform the accused person(s) of the investigation findings including any additional process involved. In an interview with Resident#3's son on at 3:00pm, he stated he was unaware that his mother had been involved in a violent incident with another resident nor informed. On , the facility informed him that his mother had . In a further interview with Resident#3's son on at 4:33pm, he stated the Administrator informed him that the facility had not been "transparent" with him and failed to completely inform him about the incident and stated Resident#3 was physically by another resident. A review of the facility's record showed no documentation showing the was internally investigated nor implemented interventions to prevent similar occurrences. In an interview with the Administrator on at 8:10pm he stated,"Resident#8 needs more than we can provide. The hospital discharged her when they shouldn't have. We can't be responsible for the hospital doing that". Class III	A 077		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must:	A 152		

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A 152	Continued From page 42 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide a clean, safe living environment free of hazards to residents and to ensure that all	A 152		

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A 152	Continued From page 43 existing architectural, mechanical, electrical, and structural systems, and appurtenances are maintained in good working order. Findings Included: 1) On at 3:54pm, observed marks on the walls in the hallways on the third floor. On the second floor, there was evidence of a strong odor of feces and . In an interview with Staff R on at 3:10pm, she stated there were marks on the walls on the third floor because the residents had ripped the pictures off the wall. In an interview with the Director of Memory Care and Activities on at 3:10pm, he stated the foul odor was present because it was "changing time" for the residents. 2) On at 8:03pm, observed a dog walking down the hallways and common areas on the second floor. In an interview with the Administrator on at 7:17pm, he stated he owned the dog and had documentation that the dog was free from in his office. Documentation was requested however was not received. A review of the facility's records showed there was no documentation showing the Administrator's dog was free from . Class III	A 152		

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A 162	Continued From page 44	A 162		
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 health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (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 paragraph 59A-36.007(1)(e), F.A.C. (f) A [illegible] 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 [illegible] recorded semi-annually.	A 162		

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A 162	Continued From page 45 (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, . . , 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,	A 162		

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A 162	Continued From page 46 guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's . . . . . , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020,	A 162		

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A 162	Continued From page 47 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to have accurate health assessments for two out of thirty two sample residents (Resident #32 and Resident #4). Findings as follow: 1. On at 3:27 PM Resident #32 was observed walking in the hallway using a walker. She was observed to have a black right , , on her right side of , and arm. On at 3:45 PM Staff U stated while working on Memory Care unit (day not recalled) Resident #32 said to her she had while putting on her shoes, and she said she did not ask for assistance or reported it to staff. She stated she got herself up and went to her bedroom and she was fine. She stated advise resident to call staff for assistance. On at 6:29 PM Resident #32 interviewed stated she had in the bathroom while putting on her shoes about a week ago. She said, " After I took a shower, I was trying to put my clothes and shoes" adding after she she get up herself, went to bed and did not inform staff working. adding, " none of staff saw me" Review of Resident #32's progress notes showed on Staff U found resident lying on the bedroom floor and she was observed holding her telling " I hit my " but she was unable to explain how it happened. Big bumps were noted on the upper part of her without .	A 162		

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A 162	Continued From page 48 Review of Resident #32's record showed the facility did not assess resident after the . There was no documentation of . precautions. Health Assessment available for review dated showed resident was not under . precautions, further review showed resident needed assistance with ambulation, bathing, , self care, toileting and transferring and it showed the Health Assessment did not specify whether resident needed nursing treatment or , , services. 2. On at At 2:45pm Resident #4's daughter stated the resident in the facility on and injured right spiral , she was hospitalized due to they believed her , was broken. Resident had not been able to walk again due to her advanced 's. Review of Resident #4's observation notes on record documented on Staff S notified the Nurse on duty that resident . Nurse went to resident's room and observed resident on the floor on her by the kitchenette complaining of . Resident was unable to tell how she , she denied , 911 was called. Paramedics assessed resident and she was not transported to the hospital. Notes on at 7:47 AM documented Staff F called Staff W to floor where resident was seen lying on the floor next to her bed. When asked what happened she stated "I went to answer the door and I ". On assessment she was unable to move her right and complained of , when touched. 911 was call and the resident was transferred to a local hospital for evaluation.	A 162		

Agency for Health Care Administration

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A 162	Continued From page 49 Review of Resident #4 health assessment available for review dated showed resident was not under . precautions. Class III	A 162		