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
	AL11968683	A. BUILDING: _____ B. WING _____	07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BANYAN PLACE	2950 NW 5TH AVENUE BOCA RATON, FL 33431

(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
CZ815	408.809(1)( ); 435.02(2); 435.06 FS Background Screening; Prohibited Offenses 408.809 Background screening; prohibited offenses.- (1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are considered employees for the purposes of conducting screening under chapter 435: (a) The licensee, if an individual. (b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider. (c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider. (d) Any person who is a controlling interest. (e) Any person, as required by authorizing statutes, seeking employment with a licensee or provider who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, with a licensee or provider whose responsibilities require him or her to provide personal care or personal services directly to clients, or with a licensee or provider to work 20 hours a week or more who will have access to client funds, personal property, or living areas. Evidence of contractor screening may be retained by the contractor's employer or the licensee. (3) All must be provided in electronic format. Screening results shall be reviewed by the agency with respect to the offenses specified in s. 435.04 and this section, and the qualifying or disqualifying status of the person named in the request shall be maintained in a database. The	CZ815		

AHCA Form 3020-0001

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

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CZ815	Continued From page 1	CZ815		

qualifying or disqualifying status of the person named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee's behalf.

(4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an . . . awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction:
(a) Any authorizing statutes, if the offense was a felony.
(b) This chapter, if the offense was a felony.
(c) Section 409.920, relating to Medicaid provider fraud.
(d) Section 409.9201, relating to Medicaid fraud.
(e) Section 741.28, relating to domestic violence.
(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.
(g) Section 784.03, relating to battery, if the victim is a adult as defined in s. 415.102 or a patient or resident of a facility licensed under chapter 395, chapter 400, or chapter 429.
(h) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.
(i) Section 817.234, relating to false and fraudulent insurance claims.
(j) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.
(k) Section 817.50, relating to fraudulently

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CZ815	Continued From page 2 obtaining goods or services from a health care provider. (l) Section 817.505, relating to patient brokering. (m) Section 817.568, relating to criminal use of personal identification information. (n) Section 817.60, relating to obtaining a credit card through fraudulent means. (o) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony. (p) Section 831.01, relating to forgery. (q) Section 831.02, relating to uttering forged instruments. (r) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes. (s) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes. (t) Section 831.30, relating to fraud in obtaining medicinal drugs. (u) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony. (v) Section 895.03, relating to racketeering and collection of unlawful debts. (w) Section 896.101, relating to the Florida Money Laundering Act. If, upon rescreening, a person who is currently employed or . . . . . with a licensee and was screened and qualified under s. 435.04 has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible	CZ815		

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CZ815	Continued From page 3 to apply for an exemption and the exemption request is received by the agency no later than 30 days after receipt of the rescreening results by the person. (5) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening. (6)(a) As provided in chapter 435, the agency may grant an exemption from disqualification to a person who is subject to this section and who: 1. Does not have an active professional license or certification from the Department of Health; or 2. Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification. (b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may grant an exemption from disqualification to a person who is subject to this section and who has received a professional license or certification from the Department of Health or a regulatory board within that department and that person is providing a service within the scope of his or her licensed or certified practice. (7) The agency and the Department of Health may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, chapter 435, and authorizing statutes requiring background screening and to implement and adopt criteria	CZ815		

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CZ815	Continued From page 4 relating to retaining [redacted] pursuant to s. 943.05(2). (8) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this section, terminates the person against whom the report was issued, whether or not that person has filed for an exemption with the Department of Health or the agency. 435.06 Exclusion from employment.- (1) If an employer or agency has reasonable cause to believe that grounds exist for the denial or termination of employment of any employee as a result of background screening, it shall notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity. (2)(a) An employer may not hire, select, or otherwise allow an employee to have contact with any person that would place the employee in a role that requires background screening until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of employment. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select, or otherwise allow the employee to have contact with any person that would place the employee in a role that requires background screening unless the employee is granted an	CZ815		

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CZ815	Continued From page 5	CZ815		

exemption for the disqualification by the agency as provided under s. 435.07.
(b) If an employer becomes aware that an employee has been for a disqualifying offense, the employer must remove the employee from contact with any person that places the employee in a role that requires background screening until the is resolved in a way that the employer determines that the employee is still eligible for employment under this chapter.
(c) The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of this chapter or place the employee in a position for which background screening is not required unless the employee is granted an exemption from disqualification pursuant to s. 435.07.
(d) An employer may hire an employee to a position that requires background screening before the employee completes the screening process for training and orientation purposes. However, the employee may not have direct contact with persons until the screening process is completed and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment.
(3) Any employee who refuses to cooperate in such screening or refuses to timely submit the information necessary to complete the screening, including , if required, must be disqualified for employment in such position or, if employed, must be dismissed.
(4) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages against, an employer that, upon notice of a conviction or for a disqualifying offense listed under this chapter,

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CZ815	Continued From page 6 terminates the person against whom the report was issued or who was , regardless of whether or not that person has filed for an exemption pursuant to this chapter. 435.02 Definitions.-For the purposes of this chapter, the term: (2) "Employee" means any person required by law to be screened pursuant to this chapter, including, but not limited to, persons who are contractors, licensees, or volunteers. This Statute or Rule is not met as evidenced by: Based on record review and interviews, it was determined that 2 of 3 sampled employees (Employees C & D) did not complete a level II background screening before beginning employment at the facility and provide dietary services to the residents. The findings included: On . . . . . ., Employees C and D were observed working in the dining room, as food service workers. Attempts to conduct interviews with the Employees were unsuccessful, they could not communicate in English. On . . . . . at 3:02 PM, the Executive Director and the Regional Operations Manager indicated that the new employees were three agency employees who were still in training. However, only one of the three employees had completed a level II background screening, upon record review. The two employees without the level II background screening were observed working in the dining room during lunch on . . . at 11:45 AM. Interview conducted with Employee A and C's	CZ815		

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CZ815	Continued From page 7 co-workers on . . . . . at 11:50 AM proved that both Employees A and B were staff and were not currently in training. Review of Employees C 's personnel file revealed that Employee C was hired on . Employee D was hired on . . . . . . Unclassified	CZ815		
CZ830	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving	CZ830		

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CZ830	Continued From page 8	CZ830		

provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers.

(3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider:

1. Suffered damage to its operation during the state of emergency.
2. Is currently licensed.
3. Does not have a provisional license.
4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months.

(b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end

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CZ830	Continued From page 9 of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on records review and interviews, it was determined that the facility did not have a current County Emergency Management Plan (CEMP) approval. The findings included. Review of the CEMP for the facility revealed that their last approved plan expired on . . . . . . On 7/. . . . . at 3:00 PM, the Executive Director reported that they have been working with the County to have their plan approved. She said that they had alreay resubmitted their plan for approval and were still awaiting for a decision from the County. Review of the Invoice, evidence of plan submision, showed that it was paid on . . . An interview with the County Emergency Management Representative on . . . confirmed that the plan was not yet approved.	CZ830		

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CZ830	Continued From page 10 Class III	CZ830		

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A 000	Initial Comments An unannounced licensure Complaint (#2023001909, #2023004447) and Generator Monitoring survey was conducted on through at Banyan Place. The facility had deficiencies related to Complaint (#2023001909) at the time of the survey.	A 000		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the 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 025		

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A 025	Continued From page 1 (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on records review and interviews, the facility failed to provide adequate supervision to ensure 1 of 1 sampled resident's safety (Resident #10). The lack of supervision led Resident #10 to be locked out of the facility on without having any means of reentering the building, and there was no one available to grant her access into the facility. The findings included: Review of an incident log showed that Resident #10, a female eloped	A 025		

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A 025	Continued From page 2 from the facility on . . . . . She was admitted on . The Executive Director said on 7/. . . . . that she was on vacation when the 'elopement' occurred. She informed me that it was a Sunday when the incident had occurred. Upon her return to the facility, the ED said that she filed the first day report on . . . . . with the Agency. The Executive Director stated, Resident #10 was up in the early hours of the morning (of . . . . .) looking for someone to talk to. She went to the front desk and when she did not see anyone there, she went out the front door, which locked behind her, and started walking. (Resident #10) was stopped down the street by a passerby and he called the Boca Raton police, who called one of her daughters, were able to bring her without any incident to the community. One of the Employees let the officer and resident into the community. The Resident's Doctor was notified. The Director of Nursing spoke to both daughters on Monday, and they stated they did not want to make any issue of this, it was an unusual occurrence in their minds. I explained that we were not a memory care community, and the doors are locked, and no one is able to get in, but people can get out, especially if there was an emergency. On . . . . . at 10:00 A. M., review of the staffing schedule for showed that there were two employees in building A and two employees in building B, on the 8:00 PM to 8:00 AM shift. The Census of the facility was nearly one hundred, nearly fifty residents per building. The current facility census record showed that Resident #10 resided in building B, . There are 19 residents on the first floor of Building A and 19 on the second floor of building	A 025		

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	AL11968683	A. BUILDING: _____ B. WING _____	07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BANYAN PLACE	2950 NW 5TH AVENUE BOCA RATON, FL 33431

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A 025	Continued From page 3 A. Some of the residents in building A have Keys to reenter the facility overnight. There are 29 residents on the first floor of building B and 33 residents on the second floor. However, there are only two employees in building B at night responsible for the resident's supervision as well as performing other assigned duties. Review of the health assessment form 1823 signed by Resident #10's physician on ..... showed that Resident #10 was not at risk for elopement. Her diagnoses included ..... , Essential Tremor, ... , Tinnitus. Special precautions: ... She also suffered from ..... ; she was fully independent for all activities of daily living (ADLs); she, had no communicable ....., was not bedridden, had no ..... , and was not a danger to self or others, and did not requiring 24-hour nursing or ..... care. On at10:56 AM Resident #10 informed that she had been living at this facility for a year. She said that it was okay living at the facility. Resident said "I have two daughters, I have the freedom to do what I want, as long as I follow the rules of the facility. I know what the rules are, she added". She continued and stated that recently, I went out to the casino, Publix and other venues with a staff from the facility. She said: I have been told that I am not supposed to go out by myself. But, when my daughters come, I sign out and go out with them. Resident #10 further indicated that at night the front doors are supposed to be closed. "I am not sure at what time they are close. When asked if she had eloped from the facility, Resident #10 said that they exaggerated the story. She said	A 025		

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A 025	Continued From page 4	A 025		

that she was told that if I ever feel scared to go to the office. So, that night of , she said that she went to the office, she sat there and she saw no one. So, she decided to go to the building across. When she walked out to the other building, the door of her building locked, there was no one there to open the door. So, she said that she returned to building (A). However, instead of walking to building A, Resident #10 said that she walked away from the building, towards the street, on the sidewalk. After walking a few yards, she realized that she was lost. She said that she panicked. She saw a young man driving down the road, she yelled for help. The young man asked her if she was drunk, she said no, the man asked her if she was on drugs, she said no, then he called the police. Resident #10 said that I was not sure what else happened, it was late, and I wanted to get to bed. I believe they had called my daughter and she had come.

One of Resident #10's daughter informed that the Police had called to let her know that they had found her mother on the street. When she arrived at the location where her mother was found, two blocks away from the facility, at another community, she accompanied her to the facility. When they arrived, there was no one in sight to open the door. The police officers used their codes to call someone from the facility then, after nearly 10 minutes one of the Staff working at the facility came and opened the door.

At 12:05 pm on , the Regional Officer (RO) reported that they had installed cameras in the entire building and there is one that monitors the front desk to see who is at the front door, all the times. He informed that there was also someone who monitored the front desk in

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A 025	Continued From page 5 building B up to midnight, including weekend. In Building A there is a bell that rings at the nursing station at night. The RO also said that the front door camera has been installed before the incident that occurred on . Also, there was a sign informing everyone to press a button to request entrance into the building after midnight. When activated, the Administrator should receive a signal on her phone, and she could remotely open the door for the resident, employee, or visitor. He was asked to demonstrate how the system functions, but he said that the Administrator's phone was not currently charged (TBD). At 12:36 PM, the Resident's daughter #2 reported that the police used her mother's cell phone to call her when they found her on . When they brough her mother , there was no one at the front desk. The police used a number (they have) and someone came down and opened up the door. Daughter #2 said, in the morning she contacted the facility's Director of Nursing (DON), on Sunday at 8:30 AM from the airport. However, the DON had no idea that this had happened. Daughter #2 said that when she first texted the DON, she replied: Was there a problem with her (my mon's) medication? I then called to speak to DON, she said. The DON, she ensued, told her that she had to tell the ED about this. The DON was shocked that this had occurred. Daughter #2 said that she later found out that the DON was no longer working at the facility. She said that she was not sure how the system works. She thought the facility was supposed to have security at night. She was informed that the facility was supposed to provide supervision at all times, to all the residents. She said that the facility did not have sufficient staff. She spoke to them about that, they	A 025		

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A 025	Continued From page 6 acknowledged it and told her that they were working on it. At 1:00 PM, on this writer walked the distance to where Resident#10 was found and electronically that the resident walked 0.34 miles away from the facility. Resident #10 crossed two intersections and stopped at an apartment building North of the facility. At 1:30 PM, the Executive Director answered that "I never receive a call at night. The phone was never forwarded to me. Forwarded calls usually went to the Managers' landlines and not cell phone. The Executive Director therefore denied having knowledge of the calls being transferred to her cell phone after hours. She said that she never received any calls from people calling after hours from the intercom system. The Executive Director also reported that the two employees who work at night in building A and the two in building B have different activities that they are engaged in at night. The Executive Director further reported that after the security guard leaves the facility at 11:00 PM, or occasionally at midnight, there is no one left to monitor the lobby of the building or the front doors. The two caregivers in Building A and the Caregivers in building B are supposed to assist residents with ADL care and do Laundry at night, informed the ED. The ED acknowledged the lack of staff necessary to provide the required supervision needed to monitor the residents' whereabout in the building. She said meanwhile that they are in the process of recruiting new employees and said that they need a better system to ensure the safety of all the residents at the facility. The RO also insinuated that providing access keys to every resident may resolve the	A 025		

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A 025	Continued From page 7 issue of the doors not being monitored at night. However, given the layout and size of the facility, lack of physical monitoring of the facility's entrance doors (in building A & B) poses a significant threat to the continued safety of residents, especially those who may exit the building and have no [illegible] ability to reenter the building with or without access keys. Class III	A 025		
A 030	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; [illegible] Rights Florida,	A 030		

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A 030	Continued From page 8 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d),	A 030		

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A 030	Continued From page 9 F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from [redacted] 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,	A 030		

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

Agency for Health Care Administration

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A 030	Continued From page 11 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 person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names	A 030		

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A 030	Continued From page 12 and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on interviews, observations, and records review, it is determined that the facility failed to treat with dignity 2 of 6 sampled residents (Resident #1 & Resident #9).	A 030		

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A 030	Continued From page 13 The findings included: Resident #1 was admitted to the facility on . On , Resident #1 was observed seating in her room at 12:26 PM. The odor coming from the room _a stench ammonia-like smell_ was so strong and overpowering that this writer could not conduct a full preliminary interview with the resident. Yet, before exiting the room, the resident quickly voiced her concern to this writer stating that she was served breakfast and lunch in her room, and she was charged for both. Thereafter, Employee A who facilitated the tour was asked to enter the resident's room to make her own assessment. After leaving the Resident's room, Employee A, confirmed that the odor in the room was unbearable. However, Employee A mused that it was because Resident #1 had a On at 12:29 PM Employee B, a licensed Practical Nurse (LPN) (Sherline) informed that Resident #1 moved into the facility on . She said that Resident #1 did not have any . She said that the resident has lymphedema, but not a that would give off odor. She said that if there is a smell, it must be odor/ammonia. Employee B also said that they are not supposed to get Resident #1's wet. Home health staff comes in to wrap the . Employee B said that she has not yet been given authorization to perform that task for Resident #1. However, once home health is done with their care, she will be doing the wrap for the resident. Employee A said that she could not even stay in the room while giving Resident #1 her	A 030		

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medications the day before. Employee A then said she inquired from the other Aide who worked with her the day before and she told her that the odor was coming from Resident #1's body.

At 12:50 PM, this writer decided to conduct the interview although no one had yet taken any action to clean up the room. Resident #1 informed that she was left wet, and they did not remove the soiled clothes out of her room. She said the odor was coming from the -soaked clothes, left on the floor next to the Resident's chair. At the hearing of that unfortunate report, this writer had decided to have the Administrator come over to assess the situation.
Ten minutes later, the Administrator arrived to the room accompanied by the Regional Operator. They quickly acknowledged the unbearable odor. After scouting the room to identify the source of the problem, they found a bag that contained some of the Resident's clothes behind the entrance door. They smelt it and concluded that the odor was not coming from that bag. They came out of the room and said that they will inquire further. No one identified the source of odor or removed the soiled clothes next to the resident despite the overwhelming odor in the room.

At 2:36 PM, the Executive Director (ED) was asked to clarify the need for the fee assessed for breakfast and lunch. The ED said that the residents are encouraged to eat in the dining room for socialization and to encourage mobility. She said that they charge a nominal fee to residents requesting room service. However, the nominal fee is not charged if the resident is ill and unable to go to the dining room. The Regional Operation Manager, present during the interview, concurred with the information provided by the

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A 030	Continued From page 15 ED. That information was also verified in the Residents' contract. Yet, Resident #1 could not go to the dining room because of her physical condition or illness. She was still charged the nominal fee. They, the ED and the ROM finally said that they were able to locate the source of the stench odor. They said that Resident #1 had [redacted]-soiled clothes on the floor. The ROM and the ED further stated that it was unacceptable to serve the resident her meals (breakfast and lunch) in that environment. They said that they had ordered to have the room cleaned. Resident #1 was admitted to the facility on [redacted]. Her AHCA form 1823 dated [redacted] showed the following diagnoses: [redacted] III; [redacted]; Hyperkalemia; [redacted]; [redacted]; [redacted]; [redacted]; Hx of [redacted]. The health assessment shows that she is independent for all ADLs. However, the resident said that she required assistance for all ADLs due to lymphedema and difficulty ambulating at this time. 2) Resident #9 reported on [redacted] at 10:02 AM, that he did not take a shower in two weeks. His room had a [redacted]-like odor and was unkempt. He said that he was given an eviction notice because he is [redacted]. His closet door was observed off the rack and set unsafely against the closet wall. The resident said that he ran into it by mistake with his scooter. He said that it would not mind if they removed it altogether. The Resident said a gentleman used to help him shower, but he had not seen him lately. At 11:55 AM, on [redacted], the Executive Director confirmed that Resident #9 was indeed	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968683	A. BUILDING: _____ B. WING _____	07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 030	Continued From page 16 . . . . . of . . and . . . . . . They asserted that they were not able to care for him and consequently served him the forty-five days-notice. The ED said that Resident #9 was sent to the hospital for a medical condition and returned to the facility with the issue. The ED also said that the resident's Physician informed her yesterday ( ) that there was nothing that he could do to resolve Resident #9's issue. Record review of Resident #9 showed an admission date of . . . . . . The health assessment (AHCA Form 1823) dated documented the diagnoses of: . . . . . , type 2 (DM2); , ... ( ); . . . . . , ... (. . . . III); , ( ); Hypertrophy ( ); and . . , . Resident #9 required assistance for all activities of daily living (adl), and supervision for eating. The Resident also required 24-hour nursing or , care. Review of Resident #9 shower schedule sheet revealed that his shower days were on Mondays, Wednesdays, and Friday. Class III	A 030		
A 152	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 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,	A 152		

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A 152	Continued From page 17 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 [illegible] 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 [illegible]. This Statute or Rule is not met as evidenced by: Based on interviews and observations, it was determined that the facility failed to maintain a clean and comfortable environment, for 4 of 4 sampled residents (Residents 1, 3, 4, & 10). The findings included:	A 152		

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A 152	Continued From page 18 Resident #4 reported on [redacted] at 11:11 AM that after acquiring a new bed, bigger than the one that the facility had provided to him, he had requested for several weeks that they remove the old bed left out of the living room of his and his roommate's Suite. The Resident voiced his frustration that his complaints have been ignored. His roommate Resident #3 also complained that he too had contacted the administrative office regarding the bedding being abandoned in their living room, yet no one seemed to care to remove them. At 12:50 PM on [redacted] Resident #1 voiced her displeasure for being left in a room saturated with [redacted] odor. The resident complained that they left her soiled clothing items on the floor next to her chair after they changed her, and they did not remove them out of her room. She further stated that she was served breakfast and lunch in the unpleasant [redacted]-saturated environment. At 11:00 AM on [redacted], the Southeast hallway near [redacted] (empty) was noted to be very warm. Residents and staff expressed their concerns, informing that the environmental condition has been that way since [redacted]. Staff complained that it is difficult to work in that environment. Residents complained that it is difficult to walk through that hallway section. An anonymous reporter said that they have [redacted] going out to the hallway and other places of the facility because the walk from the unconditioned area to the other side of the facility is not a short distance; at times, the temperature therein could be excessive. At 10:53 AM on [redacted] the odor in [redacted] was noted to be unpleasant and unsanitary. The closet door at the entrance of the room, which the	A 152		

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A 152	Continued From page 19 resident acknowledged to have been responsible for inadvertently unhinging with his scooter, was left leaning against the wall. The door's position posed an impending danger to the resident's safety . The refuse area located on the Westside of the second floor, in building B was unkempt and emitted an offensive odor that permeated through the hallways near Residents' rooms. The garbage cans in that room were uncovered, dirty, and heavily stained. The findings were discussed with the Administration during the survey process. The Executive Director said that they have been working towards changing the air contioning system on that section of the second floor of Building B, however the process takes time. However, they had not implemented any temporary measures. The ED and Regional Operation Manager (ROM) stated that they were not aware of Resident # 3 and #4's complaint. During the Exit meeting they said that they will take appropriate and necessary corrective actions to rectify those situations. Class III	A 152		