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
	AL11965334	A. BUILDING: _____ B. WING _____	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS OF WINTER SPRINGS	1057 WILLA SPRINGS DRIVE WINTER SPRINGS, FL 32708

(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 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known ␣ the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical ␣, the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure medication for 1 of 4 sampled residents was properly charted (#1). Findings:	A 054		

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A 054	Continued From page 1 A record review revealed the facility's admission date of . . . . . A . . . . . health assessment form (1823) indicated a history of . . . . . 's, ... needs assistance with all Activities of Daily Living, needs medication administration, and identified as a risk. On Resident #1's Medication Observation Record revealed on . . . . . the medication for . . . . . , Dx: . . . . . 's and . . . . . Dx: . . . was not documented as administered. Resident #1's family member stated during a phone call she believed the facility failed to provide her husband his 's medication. Resident #1's family member stated it was documented by his doctor the facility will need to administer. On . . . . . at 12:21pm Nurse E was contacted by phone with no return call received. On at 3:45 pm The Administrator stated the only time resident #1 was out of the facility was during his time in Rehab from . . . . . . The facilities Medication Pass Policy dated states on page 2 "Administration medication - Document initials on MAR for each medication administered." On at 3:55 pm The Resident Service Coordinator confirmed the findings and initials of Nurse E who was scheduled and failed to document resident #1 medications on	A 054		

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A 054	Continued From page 2 Class III	A 054		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or	A 078		

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A 078	Continued From page 3 certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility . . . . . to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to obtain documented evidence for 1 of 3 sampled staff (C) submitted a onetime statement they are free of communicable including . . status within 30 days of employment as required. 59A-36.010(2) FAC Findings: Review of Caregiver C's record revealed a hire	A 078		

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A 078	Continued From page 4 date . .. . There was no documented evidence of the status within 30 days employment or annually. On . ... at 3:45 pm - The Resident Service Coordinator confirmed the findings. Class III	A 078		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION.	A 081		

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A 081	Continued From page 5 (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in [illegible] control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its [illegible] control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to [illegible] borne [illegible], may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers	A 081		

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A 081	Continued From page 6 the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , ... The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response	A 081		

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A 081	Continued From page 7 policies and procedures. This Statute or Rule is not met as evidenced by: Based on review of the facility's documented elopement drills, personnel record reviews and interview, the facility failed to have documentation that 3 of 3 sampled staff participated in a minimum of two resident elopement drills each year (A, B & C). Findings: Review of personnel records revealed Caregiver A was hired on [redacted], Caregiver B on [redacted], and Caregiver C on [redacted]. On [redacted] at 3:00 pm, the elopement drills records requested for review revealed no documentation whether caregiver A, B or C participated in the drills. On [redacted] at 3:10 pm, the Administrator and Resident Service Coordinator confirmed the findings and was unable to provide any drills. Class III	A 081		
A 000	Initial Comments Complaint investigations #2023007240 & #2023008378 were conducted at Arden Courts of Winter Springs on [redacted]. The facility had deficiencies at the time of the survey.	A 000		
A 010 SS=D	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency	A 010		

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A 010	Continued From page 8 429.26 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. (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.	A 010		

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A 010	Continued From page 9 (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 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	A 010		

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A 010	Continued From page 10 (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 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:	A 010		

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A 010	Continued From page 11 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, 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 resident record review, observation, and interview, the facility failed to obtain a new AHCA Form, 1823 Health Assessment completed by the healthcare provider for continued residency after a significant change for 1 of 1 sampled resident (#3) as required in an assisted	A 010		

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A 010	Continued From page 12 living facility (ALF). Findings: A record review revealed a facility's admission date of . A health assessment form (1823) indicated a history of -behavioral disturbance, , and was not identified as an elopement risk. A facility note on at 18:31 read, "Resident observed stuck in the bushes during a sweep. Resident was assisted to a wheelchair and escorted to his house. A facility note on at 8:06 read, "Writer found 0530 outside of courtyard in of Country Lane and Garden area. Writer observed resident laying in shrub on right side. Paramedics arrived at 540 and assessed resident. He was transported to Medical Hospital for evaluation." A facility note on at 18:26 read, "Resident found on the ground outside in the shrubs. On at 3:55pm The Administrator and Resident Service Coordinator felt as though resident #3 did not elopement being he was still on property in the courtyard. On at 3:55pm The Administrator and Resident Service Coordinator confirmed the findings. Class III	A 010		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision	A 025		

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A 025	Continued From page 13 429.26 (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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ARDEN COURTS OF WINTER SPRINGS	1057 WILLA SPRINGS DRIVE WINTER SPRINGS, FL 32708

(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 025	Continued From page 14 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 observations, record reviews and interviews, the facility failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision and ensure safety through proactive measures to minimize the potential for and injuries for 2 of 4 sampled resident (#1 &#3). Findings: 1. A record review revealed a facility's admission date of for Resident #3. A health assessment form (1823) indicated a history of -behavioral disturbance, and was identified as a risk. A facility's service plan initiated on reads, "Help identify and avoid , producing situations, redirect as needed. Monitor for exit seeking behavior, resident is on safety checks for every hour. At risk for elopement."	A 025		

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A 025	Continued From page 15 A facility note on [illegible] at 12:03 read, "Resident #3 also has had private duty in place for resident's safety since resident is a risk and paces a lot till exhaustion. Remains with 24 hour sitters at this time for safety." A facility note on [illegible] at 1:23 read, "Resident #3 personal care aid, stated resident was agitated and trying to be combative. Resident appears restless and agitated, walking around house." A facility note on [illegible] at 1:38 read, "Resident #3 is up and walking around. Resident remains a [illegible] risk. Unable to redirect resident to bed or chair." A facility note on at 3:21 read, "personal aid states that resident was ambulating, holding on to table, when he to the floor, on his left side." A facility note on [illegible] at 18:31 read, "Resident #3 observed stuck in the bushes during a sweep. Resident was assisted to a wheelchair and escorted to his house. Care staff cleaned his [illegible] where he received [illegible] on his cheek from the bush." A facility note on at 10:00 read, "Resident #3 returned from ER via transport. Resident has a aid to the forehead and [illegible] intact on the right arm." A facility note on [illegible] at 10:46 read, "Resident #3 came into community from hospital with bandage wrap to the right arm." A facility note on [illegible] at 8:06 read, "Writer found 0530 outside of courtyard in of	A 025		

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A 025	Continued From page 16 Country Lane and Garden area. Writer observed resident laying in shrub on right side. Writer immediately alert staff to stay at resident side and writer called 911 to have resident transfer to ER. Paramedics arrived at 540 and assessed resident. He was transported to Medical Hospital for evaluation." A facility note on . . . . . at 11:27 read, "Resident #3 continues to walk the community at a fast pace, while bending forward." A facility note on . . . . . at 18:26 read, "Resident #3 found on the ground outside in the shrubs. Left side of . . . with . . . . . that was cleaned. Red marks noted to both left and right arms. Resident brought to his room for a nap after his lunch." A facility note on at 14:45 read, "Caregiver heard a noise in the house dining room, found resident #3 on the floor on his . . . . . partly leaning down on his . . . ." A facility note on . . . . . at 18:34 read, "Resident #3 was found in house hallway on his . . . , holding on to the rail with his right . . . ." On . . . . . at 9:37am Resident #3 was observed walking throughout the facility nonstop at what appeared to be a moderate pace. Resident #3's private sitter stated she had been with him for about three weeks. The private sitter stated the family requested the sitters due to resident #3 getting out but she was not present during that time. On at 10:32am Caregiver B stated prior to resident #3 getting out he did not have a sitter or an ID bracelet.	A 025		

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A 025	Continued From page 17 On at 12:31pm Caregiver C stated upon arrival at 11pm to the facility she saw resident #3's pants between the entry to Country where resident #3 lives by the staff breakroom. Caregiver C stated she did not think much of it because resident #3 always takes off his clothes. Caregiver C she was in the process of changing residents between 4:30am - 5am when Caregiver D announced she could not find resident #3. Caregiver C stated we went to look and check all the rooms and closets in each house and resident #3 was not there. Caregiver C stated she went outside in the courtyard but did not see resident #3 as it was still a bit dark. Caregiver C stated she returned inside stating she did not see resident #3 and begun to do another sweep of the rooms and closets. Caregiver C stated she returned outside with Caregiver F because it was getting light to check again. Caregiver C stated Caregiver F brought a flashlight and then we were able to see resident #3. Resident #3 was alert and alive so we called the ambulance. We stayed with resident #3 until the ambulance arrived. On at 12:52pm Caregiver D stated I worked on the unit where resident #3 lived. Caregiver D stated the resident was non-complaint and aggressive and would not come to his unit. Caregiver D stated the last time she checked on resident #3 was at 9:30pm. Caregiver D stated she completed rounds again at 1pm and thinks resident #3 was in the Boat Unit sitting in a chair. Caregiver D stated she tried to get him up and he started swinging. Caregiver D stated the facility allows the residents to stay in other houses at night. Caregiver D stated she returned at 3am and saw the resident walking around, but was unable to provide the exact locations. Caregiver D stated she returned at 5am	A 025		

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A 025	Continued From page 18 to the Boat house and resident #3 was not there. Caregiver D stated she looked for resident #3 and then told the nurse. Caregiver D stated she checked everywhere outside but could not find resident #3. On . . . . . at 8:45am The Resident Service Coordinator could not confirm the door the resident went out. The RSC states the alarm sounds when the door is opened after hours. All other caregivers stated they heard the alarm but unable to recall which door was set off. The RSC stated each unit has a panel which displays the areas that are monitored with alarms. Once the doors lock around 7pm, when a resident pushes on the door to exit the panel will light up indicating which door was triggered. Each caregiver is responsible for their unit and completing a sweep of their residents. If no one is missing on their unit they are not required to immediately go to another unit. They will wait until their notified by the other care staff if a resident is missing. The facilities Safety and Security of Residents for Procedures for Responding to Door Alarms and Resident Elopement read, "Determine which door triggered the alarm, either by going to the panel or recognizing alarm sound for specific door, immediately go to the door to determine how the alarm was activated, complete initial evaluation of situation, If it it is clear who set off the alarm, react to the alarm. If all residents are accounted for, the alarm may be reset." On . . . . . at 3:45pm The Administrator and Resident Service Coordinator was unable to provide a clear answer as to the reset of the alarm on the day resident #3 went missing. The facilities witness statement provided by	A 025		

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A 025	Continued From page 19 Caregiver D on [redacted] at 10am read, "I last saw resident at 9am on [redacted]. I did not realize resident was outside when I checked on him at the hourly check. I heard door alarms going off around 9pm the prior day on [redacted]. I notified nurse around 5:30am on [redacted] that the resident was missing. I did not check on the resident every hour but I initialed on the hourly check sheet that I did. The facilities witness statement provided by Caregiver C on [redacted] at 9:30am read, "I only heard alarms go off early in the night. I started work at 7pm on Thursday. I never saw resident #3 last night until we all was looking for him this morning." The facilities witness statement provided by Caregiver F on [redacted] at 5:45am read, "Caregiver did not hear any alarms went she came in at night around 11pm on [redacted]. Did not see resident #3 all night." The facilities investigation and conclusion report on [redacted] read, "Resident #3 was observed outside laying in the bushes at approx. 0545am after a full community search. Due to his condition nurse called 911 to transport resident to the hospital for further evaluation. Caregiver D reported resident #3 missing at 0530am on [redacted] and admitted she did not see the resident all night. Caregiver assumed resident #3 was in another house." "Caregiver D last seen resident #3 at 9pm on [redacted]. Caregiver D did not do a visual hourly check on resident #3 and falsified documention of hourly check sheet on resident's whereabouts. Caregiver D stated her shift on [redacted] at 7pm and worked overnight. Caregiver D admitted she	A 025		

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A 025	Continued From page 20 did not see resident #3 all night. Caregiver D worked in the resident's house section which she was responsible to know his whereabouts every hour." 2. A record review revealed a facility's admission date of for Resident #1. A health assessment form (1823) indicated a history of , , 's, , , needs assistance with all Activities of Daily Living, needs medication administration, and identified as a risk. On at 10:32am Caregiver B stated resident #1 had 's, used a walker, and wore pads. Caregiver B stated that resident #1's wife stated the pads were used because when he would walk, he would freeze up and drop to his . Caregiver B stated resident #1 had constant and , suggested he use his wheelchair for safety reasons. A facility note on at 11:45 read, "Resident #1 used walker to assist with ambulation and balance. Resident has involuntary movements with the especially lower extremities tend to drag when ambulating with walker at times. A facility note on at 13:07 read, "Resident #1 put himself to the floor. Staff encourages resident to stay in his wheelchair for his safety and safety for the staff." A facility note on at 14:17 read, "Resident #1 observed on the floor in his bedroom during an hourly check." A facility note on at 12:50 read, "At	A 025		

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A 025	Continued From page 21 approx.12:50pm resident #1 observed on floor in the hallway of cottage place laying more on the left side of his ..." A facility note on ... at 7:40 read, "Resident #1 was halfway in his bathroom this morning unable to move and .. on the bathroom and bedroom floor." A facility note on at 19:15 read, "Resident#1 .. .... and having difficulty moving." A facility note on at 17:02 read, Resident #1 unstable most of the day." A facility note on ..... at 11:09 read, "Resident #1 is going to Rehab today." Resident #1 wife stated resident and had to be moved to a Rehab place. A facility note on .... at 19:45 read, "Approximately at 7:45pm, the resident #1 was found on the floor at the backyard behind the activity room. The resident had a bump below his right ... A facility note on .... at 15:06 read, "Resident #1 was observed on the floor in his bedroom during a resident check; with his ... tucked bend and leaning more on his right side. A facility note on at 13:20 read, "Resident #1 was in the hallway of cottage observed on the floor with wheelchair turned over. A facility note on at 10:23 read, "Caregiver found resident #1 outside in the courtyard on his and in front of his wheelchair."	A 025		

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A 025	Continued From page 22 A facility note on at 3:00 read, "During a courtyard sweep, resident #1 was observed outside with him and the wheelchair was turned over on resident's left side." On at 3:55pm The Administrator and Resident Service Coordinator confirmed the findings. Class II	A 025		
A 030 SS=D	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; , Rights Florida,	A 030		

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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),

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A 030	Continued From page 24 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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A 030	Continued From page 25 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	A 030		

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

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A 030	Continued From page 27 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 resident record review and interview the facility failed to issue a 45 days' notice of relocation or termination of residency to 1 of 1 sampled resident (#1).	A 030		

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	AL11965334	A. BUILDING: _____ B. WING _____	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 030	Continued From page 28 Findings: A record review revealed the facility's admission date of [redacted]. A [redacted] health assessment form (1823) indicated a history of [redacted]'s, needs assistance with all Activities of Daily Living, needs medication administration, and identified as a [redacted] risk. On [redacted] at 3:55pm The Administrator and RSC stated resident #1's wife would bring boxes of medication and ask the staff to take the medication. The staff would decline because the medications were not properly labeled therefore, the facility was unable to provide to resident #1. On [redacted] at 3:55pm The Administrator stated she completed the Concern Form based on the concerns and issues addressed by resident #1 wife. The Administrator stated she asked resident #1's wife to come in to discuss the concerns stated on the grievance. Resident #1's wife stated her husband was not given 45 days' notice. The facility stated they could no longer care for him as he was declining so quickly. On [redacted] at 3:55pm The Administrator stated a 45 days' notice was not issued because resident #1's wife came and removed his belongings. The Administrator stated I have an email that I can read to you that talks about the move out, but I cannot provide it because it's an internal document. On [redacted] at 3:55pm The document was not read nor was it provided to show proof that it	A 030		

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A 030	Continued From page 29 existed. Class III	A 030		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo	A 032		

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A 032	Continued From page 30 identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure 1 of 1 sampled resident with a history of elopement was identified with their identification (ID) on their person that included their name and the facility's name, address, and telephone number (#3). Findings: A record review revealed a facility's admission	A 032		

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A 032	Continued From page 31 date of . . . . . A . . . . . health assessment form (1823) indicated a history of . . . . . -behavioral disturbance, ... , and was identified as a risk. A facility's service plan initiated on reads, "Help identify and avoid . . , producing situations, redirect as needed. Monitor for exit seeking behavior, resident is on safety checks for every hour. At risk for elopement." A facility note on at 18:31 read, "Resident observed stuck in the bushes during a sweep. Resident was assisted to a wheelchair and escorted . . . to his house. Care staff cleaned his where he received . on his cheek from the bush." A facility note on . . . . . at 8:06 read, "Writer found 0530 outside of courtyard in of Country Lane and Garden area. Writer observed resident laying in shrub on right side. Writer immediately alert staff to stay at resident side and writer called 911 to have resident transfer to ER. Paramedics arrived at 540 and assessed resident. He was transported to Medical Hospital for evaluation." A facility note on . . . . . at 18:26 read, "Resident found on the ground outside in the shrubs. Left side of . . . with . . . . . that was cleaned. Red marks noted to both left and right arms. On . . . . . at 9:37am Resident #3's private sitter stated she was not working during the time resident #3 went missing. She stated the facility has since placed the bracelet on his which has his name, the address and phone number of the facility.	A 032		

Agency for Health Care Administration

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A 032	Continued From page 32 Observation of resident #1 on at 10:00 AM revealed that he had identification on, On at 10:32am Caregiver B stated prior to resident #3 getting out he did not have a sitter or an ID bracelet. On at 12:31pm Caregiver C stated upon arrival at 11pm to the facility she saw resident #3's pants between the entry to Country where resident #3 lives by the staff breakroom. Caregiver C stated she did not think much of it because resident #3 always takes off his clothes. Caregiver C she was in the process of changing residents between 4:30am - 5am when Caregiver D announced she could not find resident #3. Caregiver C stated we went to look and check all the rooms and closets in each house and resident #3 was not there. Caregiver C stated she went outside in the courtyard but did not see resident #3 as it was still a bit dark. Caregiver C stated she returned inside stating she did not see resident #3 and begun to do another sweep of the rooms and closets. Caregiver C stated she returned outside with Caregiver F because it was getting light to check again. Caregiver C stated Caregiver F brought a flashlight and then we were able to see resident #3. Resident #3 was alert and alive so we called the ambulance. We stayed with resident #3 until the ambulance arrived. On at 12:52pm Caregiver D stated I worked on the unit where resident #3 lived. Caregiver D stated the resident was non-complaint and aggressive and would not come to his unit. Caregiver D stated the last time she checked on resident #3 was at 9:30pm. Caregiver D stated she completed rounds again at 1pm and thinks resident #3 was in the Boat	A 032		

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A 032	Continued From page 33 Unit sitting in a chair. Caregiver D stated she tried to get him up and he started swinging. Caregiver D stated the facility allows the residents to stay in other houses at night. Caregiver D stated she returned at 3am and saw the resident walking around, but was unable to provide the exact locations. Caregiver D stated she returned at 5am to the Boat house and resident #3 was not there. Caregiver D stated she looked for resident #3 and then told the nurse. Caregiver D stated she checked everywhere outside but could not find resident #3. On at 8:45am The Resident Service Coordinator could not confirm the door the resident went out. The RSC states the alarm sounds when the door is opened after hours. All other caregivers stated they heard the alarm but unable to recall which door was set off. The RSC stated each unit has a panel which displays the areas that are monitored with alarms. Once the doors lock around 7pm, when a resident pushes on the door to exit the panel will light up indicating which door was triggered. Each caregiver is responsible for their unit and completing a sweep of their residents. If no one is missing on their unit they are not required to immediately go to another unit. They will wait until their notified by the other care staff if a resident is missing. On at 3:45pm The Administrator and Resident Service Coordinator was unable to provide a clear answer as to the reset of the alarm on the day resident #3 went missing. The Administrator and RSC felt as though resident #3 did not elopement being he was still on property in the courtyard. The facilities Safety and Security of Residents for Procedures for Responding to Door Alarms and	A 032		

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A 032	Continued From page 34 Resident Elopement read, "Determine which door triggered the alarm, either by going to the panel or recognizing alarm sound for specific door, immediately go to the door to determine how the alarm was activated, complete initial evaluation of situation, If it it is clear who set off the alarm, react to the alarm. If all residents are accounted for, the alarm may be reset." The facilities witness statement provided by Caregiver D on [redacted] at 10am read, "I last saw resident at 9am on [redacted]. I did not realize resident was outside when I checked on him at the hourly check. I heard door alarms going off around 9pm the prior day on [redacted]. I notified nurse around 5:30am on [redacted] that the resident was missing. I did not check on the resident every hour but I initial on the hourly check sheet that I did. The facilities witness statement provided by Caregiver C on [redacted] at 9:30am read, "I only heard alarms go off early in the night. I started work at 7pm on Thursday. I never saw resident #3 last night until we all was looking for him this morning." The facilities witness statement provided by Caregiver F on [redacted] at 5:45am read, "Caregiver did not hear any alarms went she came in at night around 11pm on [redacted]. Did not see resident #3 all night." The facilities investigation and conclusion report on [redacted] read, "Resident #3 was observed outside laying in the bushes at approx. 0545am after a full community search. Due to his condition nurse called 911 to transport resident to the hospital for further evaluation. Caregiver D reported resident #3 missing at 0530am on	A 032		

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A 032	Continued From page 35 .. .. and admitted she did not see the resident all night. Caregiver assumed resident #3 was in another house." "Caregiver D last seen resident #3 at 9pm on . Caregiver D did not do a visual hourly check on resident #3 and false documented on hourly check sheet on resident's whereabouts. Caregiver D stated her shift on .. .. at 7pm and worked overnight. Caregiver D admitted she did not see resident #3 all night. Caregiver D worked in the resident's house section which she was responsible to know his whereabouts every hour." On at 3:55pm The Administrator and Resident Service Coordinator confirmed the findings. Class II	A 032		
A 053 SS=D	59A-36.008(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION. (a) For facilities that provide medication administration, a staff member licensed to administer medications must be available to administer medications in accordance with a health care provider's order or prescription label. (b) Unusual reactions to the medication or a significant change in the resident's health or behavior that may be caused by the medication must be documented in the resident's record and reported immediately to the resident's health care provider. The contact with the health care provider must also be documented in the resident's record. (c) Medication administration includes conducting any examination or other procedure necessary	A 053		

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A 053	Continued From page 36 for the proper administration of medication that the resident cannot conduct personally and that can be performed by licensed staff. (d) A facility that performs clinical laboratory tests for residents, including testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Chapter 483, Part I, F.S. A valid copy of the federal CLIA Certificate must be maintained in the facility. A federal CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a federal CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents' equipment. Information about the federal CLIA Certificate is available from the Laboratory and In-Home Services Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)412-4500. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 1 of 4 residents received medication administration. (#1) Findings: A record review revealed the facility's admission date of . A health assessment form (1823) indicated a history of , needs assistance with all Activities of Daily Living, needs medication administration, and identified as a risk. Resident #1's family member stated she believed the facility failed to provide her husband his	A 053		

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A 053	Continued From page 37 's medication. Resident #1's family member stated it was documented by his doctor the facility will need to administer his medications. Resident #1's family member stated she spoke with the Administrator regarding her husband's medications that were not given. On at 10:32am Caregiver B stated every time the nurse provided resident #1 his medications, he would document it in his little black book. On Resident #1's Medication Observation Record revealed on the medication for , Dx: 's and , Dx: was not documented as administered. On at 12:21pm Nurse E was contacted by phone with no return call received. On at 3:45 pm The Administrator stated the only time resident #1 was out of the facility was during his time in Rehab from . On at 3:55 pm The Resident Service Coordinator confirmed the findings and initials of Nurse E who was scheduled and failed to document resident #1 medications on . Class III	A 053		