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
	AL11970096	A. BUILDING: _____ B. WING _____	09/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS SENIOR LIVING RESERVE OF IDLEWILD LL	18420 EXCITING IDLEWILD BLVD LUTZ, FL 33549

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation (complaint number: 2023012909) and a generator monitoring were conducted at Angels Senior Living Reserve of Idlewild on . . . . . Deficiencies were identified at the time of survey.	A 000		
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 .	A 078		

AHCA Form 3020-0001

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

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A 078	Continued From page 1 (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility . . . . . to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain evidence of a negative . . . . . ( ) examination and a one-time statement that the employee was free from communicable . . . . . from a health care provider for five employees (Staff A, Staff B, Staff	A 078		

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A 078	Continued From page 2 D, Staff E, and Staff F) of eight sampled employees. Findings Included: A record review for Staff A, conducted on . . . . . , revealed that Staff A had a negative examination on . There was no evidence for the year 2023 that Staff A was free from in Staff A's employee record. Staff A was hired on . . . . . . A record review for Staff B, conducted on , revealed that Staff B had a negative examination on . . . . There was no evidence for the year 2023 that Staff B was free from in Staff B's employee record. Staff B was hired on . A record review for Staff D, Staff E, and Staff F, conducted on . . . . . , revealed that Staff D, Staff E, and Staff F's employee records did have evidence that the employees were free from . Staff D, Staff E, and Staff F's employee records did not contain a one-time statement from a health care provider that the employee was free from communicable . . . . Staff D was hired on . Staff E was hired on . , and Staff F was hired on . . . . . . During an interview with Staff A, Staff B, and Staff C conducted on from 03:20pm through 03:25pm, Staff A, Staff B, and Staff C agreed that Staff A and Staff B did not have a statement annually that the employees were free from . Staff A, Staff B, and Staff C agreed that Staff D, Staff E, and Staff F did not have evidence that the employees were free from and did not have a one-time statement that the employees were free from communicable . . .	A 078		

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A 078	Continued From page 3 Class III	A 078		
A 152 SS=D	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, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and	A 152		

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A 152	Continued From page 4 personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that all existing mechanical, electrical, and structural systems were maintained in good working order for camera systems and two of four entry/exit doors in the memory care unit. Findings Included: A review of a self-reported document provided to the Agency, conducted on , revealed that Resident #1 eloped from the facility's memory care unit on . During observations of the memory care unit, conducted on from 01:15pm through 01:45pm, there were signs posted on the northwest facing double door, the southwest facing double door, and the northeast facing single door that noted that the doors would release upon pushing on the door for fifteen seconds in the event of an emergency. The northwest facing double door that led from the memory care unit to the parking lot the right-side door easily opened and was not locked. Staff B (Administrator in Training) reset the door with a passcode and the door continued not to lock and opened easily. Staff B reset the door for the second time and the right door continued not to lock and opened easily. Staff B reset the door for a third time and the right door continued not to lock and opened easily. The fourth time that Staff B reset the door, the right door locked and was unable to be opened. Upon pushing on the door	A 152		

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A 152	Continued From page 5 for greater than fifteen seconds, the door did not break away in the event of a fire or other emergency. Staff B reset the door and the door continued not to break away upon pushing the door for more than fifteen seconds. Staff B reset the door again and the right door opened but would not immediately lock upon shutting. The northeast facing single exit door did not break away upon pushing the door for more than fifteen seconds. Staff C (Administrator in Training) checked the bottom lock to the right-side of the northwest facility door and the door was not locking. During an interview with Staff B, conducted on at 01:30pm, Staff B stated that the doors were not checked after Resident #1 eloped from the memory care unit on . Staff B stated that the northwest door was used frequently by staff, family, and visitors into and out of the memory care unit. Staff B agreed that the northwest and northeast doors were not functioning properly. During an attempt to review the video camera feed for during the time that Resident #1 eloped from the facility, conducted on , the video camera feed was not provided. During an interview with Staff C, conducted on at 01:35pm, Staff C stated that there was no video camera feed from because the new camera went down. Staff C stated that the facility did not have the memory care doors inspected for proper function after Resident #1 eloped from the facility on . At 01:45pm, Staff C agreed that the northwest and northeast memory care doors were not functioning properly.	A 152		

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A 152	Continued From page 6 During an attempt to review repair or replacement of the video camera system, conducted on , there was no evidence that the video camera system was inspected, repaired, or replaced. Class III	A 152		
AE210 SS=D	59A-36.011(8) FAC ECC - Training (8) EXTENDED CONGREGATE CARE (ECC) TRAINING. (a) The administrator and ECC supervisor, if different from the administrator, must complete core training and 4 hours of initial training in extended congregate care prior to the facility receiving its ECC license or within 3 months of beginning employment in a currently licensed ECC facility as an administrator or ECC supervisor. Successful completion of the assisted living facility core training shall be a prerequisite for this training. ECC supervisors who attended the assisted living facility core training prior to , shall not be required to take the assisted living facility core training competency test. (b) The administrator and the ECC supervisor, if different from the administrator, must complete a minimum of 4 hours of continuing education every two years in topics relating to the physical, , or social needs of frail elderly and persons, or persons with 's or related . (c) All direct care staff providing care to residents in an ECC program must complete at least 2 hours of in-service training, provided by the facility administrator or ECC supervisor, within 6 months of beginning employment in the facility.	AE210		

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AE210	Continued From page 7 The training must address ECC concepts and requirements, including statutory and rule requirements, and the delivery of personal care and supportive services in an ECC facility. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that all direct care staff completed two-hours of Extended Congregate Care (ECC) training within six months of employment for four employees (Staff A, Staff F, Staff H, and Staff I) of five sampled employees. Findings Included: A review of the Facility's license, conducted on . . . . . , revealed that the facility held a specialty ECC license. A record review for Staff A, Staff F, Staff H, and Staff I, conducted on . . . . . , revealed that Staff A, Staff F, Staff H, and Staff Idid not have evidence that they completed a two-hours ECC training within six months of employment. Staff A was hired on . . . . . Staff F was hired on . Staff H was hired on . Staff I was hired on . . . . . . During an interview with Staff A, Staff B, and Staff C conducted on from 03:20pm through 03:22pm, Staff A, Staff B, and Staff C agreed that Staff A, Staff F, Staff H, and Staff I's employee records did not contain evidence that they had obtained two-hours of ECC training within six months of employment. Class III	AE210		

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A 000	Initial Comments A complaint investigation (complaint number: 2023012909) and a generator monitoring were conducted at Angels Senior Living Reserve of Idlewild on . . . . . Deficiencies were identified at the time of survey.	A 000		
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 .	A 078		

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A 078	Continued From page 1 (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility . . . . . to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain evidence of a negative . . . . . ( ) examination and a one-time statement that the employee was free from communicable . . . . . from a health care provider for five employees (Staff A, Staff B, Staff	A 078		

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A 078	Continued From page 2 D, Staff E, and Staff F) of eight sampled employees. Findings Included: A record review for Staff A, conducted on . . . . . , revealed that Staff A had a negative examination on . There was no evidence for the year 2023 that Staff A was free from in Staff A's employee record. Staff A was hired on . . . . . . A record review for Staff B, conducted on , revealed that Staff B had a negative examination on . . . . There was no evidence for the year 2023 that Staff B was free from in Staff B's employee record. Staff B was hired on . A record review for Staff D, Staff E, and Staff F, conducted on . . . . . , revealed that Staff D, Staff E, and Staff F's employee records did have evidence that the employees were free from . Staff D, Staff E, and Staff F's employee records did not contain a one-time statement from a health care provider that the employee was free from communicable . . . . Staff D was hired on . Staff E was hired on , and Staff F was hired on . . . . . . During an interview with Staff A, Staff B, and Staff C conducted on from 03:20pm through 03:25pm, Staff A, Staff B, and Staff C agreed that Staff A and Staff B did not have a statement annually that the employees were free from . Staff A, Staff B, and Staff C agreed that Staff D, Staff E, and Staff F did not have evidence that the employees were free from and did not have a one-time statement that the employees were free from communicable . . .	A 078		

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A 078	Continued From page 3 Class III	A 078		
A 152 SS=D	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, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and	A 152		

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A 152	Continued From page 4 personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that all existing mechanical, electrical, and structural systems were maintained in good working order for camera systems and two of four entry/exit doors in the memory care unit. Findings Included: A review of a self-reported document provided to the Agency, conducted on , revealed that Resident #1 eloped from the facility's memory care unit on . During observations of the memory care unit, conducted on from 01:15pm through 01:45pm, there were signs posted on the northwest facing double door, the southwest facing double door, and the northeast facing single door that noted that the doors would release upon pushing on the door for fifteen seconds in the event of an emergency. The northwest facing double door that led from the memory care unit to the parking lot the right-side door easily opened and was not locked. Staff B (Administrator in Training) reset the door with a passcode and the door continued not to lock and opened easily. Staff B reset the door for the second time and the right door continued not to lock and opened easily. Staff B reset the door for a third time and the right door continued not to lock and opened easily. The fourth time that Staff B reset the door, the right door locked and was unable to be opened. Upon pushing on the door	A 152		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 152	Continued From page 5 for greater than fifteen seconds, the door did not break away in the event of a fire or other emergency. Staff B reset the door and the door continued not to break away upon pushing the door for more than fifteen seconds. Staff B reset the door again and the right door opened but would not immediately lock upon shutting. The northeast facing single exit door did not break away upon pushing the door for more than fifteen seconds. Staff C (Administrator in Training) checked the bottom lock to the right-side of the northwest facility door and the door was not locking. During an interview with Staff B, conducted on at 01:30pm, Staff B stated that the doors were not checked after Resident #1 eloped from the memory care unit on . Staff B stated that the northwest door was used frequently by staff, family, and visitors into and out of the memory care unit. Staff B agreed that the northwest and northeast doors were not functioning properly. During an attempt to review the video camera feed for during the time that Resident #1 eloped from the facility, conducted on , the video camera feed was not provided. During an interview with Staff C, conducted on at 01:35pm, Staff C stated that there was no video camera feed from because the new camera went down. Staff C stated that the facility did not have the memory care doors inspected for proper function after Resident #1 eloped from the facility on . At 01:45pm, Staff C agreed that the northwest and northeast memory care doors were not functioning properly.	A 152		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11970096	A. BUILDING: _____ B. WING _____	09/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS SENIOR LIVING RESERVE OF IDLEWILD LL	18420 EXCITING IDLEWILD BLVD LUTZ, FL 33549

(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 152	Continued From page 6 During an attempt to review repair or replacement of the video camera system, conducted on , there was no evidence that the video camera system was inspected, repaired, or replaced. Class III	A 152		
AE210 SS=D	59A-36.011(8) FAC ECC - Training (8) EXTENDED CONGREGATE CARE (ECC) TRAINING. (a) The administrator and ECC supervisor, if different from the administrator, must complete core training and 4 hours of initial training in extended congregate care prior to the facility receiving its ECC license or within 3 months of beginning employment in a currently licensed ECC facility as an administrator or ECC supervisor. Successful completion of the assisted living facility core training shall be a prerequisite for this training. ECC supervisors who attended the assisted living facility core training prior to , shall not be required to take the assisted living facility core training competency test. (b) The administrator and the ECC supervisor, if different from the administrator, must complete a minimum of 4 hours of continuing education every two years in topics relating to the physical, , or social needs of frail elderly and persons, or persons with 's or related . (c) All direct care staff providing care to residents in an ECC program must complete at least 2 hours of in-service training, provided by the facility administrator or ECC supervisor, within 6 months of beginning employment in the facility.	AE210		

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
	AL11970096	A. BUILDING: _____ B. WING _____	09/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS SENIOR LIVING RESERVE OF IDLEWILD LL	18420 EXCITING IDLEWILD BLVD LUTZ, FL 33549

(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
AE210	Continued From page 7 The training must address ECC concepts and requirements, including statutory and rule requirements, and the delivery of personal care and supportive services in an ECC facility. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that all direct care staff completed two-hours of Extended Congregate Care (ECC) training within six months of employment for four employees (Staff A, Staff F, Staff H, and Staff I) of five sampled employees. Findings Included: A review of the Facility's license, conducted on [redacted], revealed that the facility held a specialty ECC license. A record review for Staff A, Staff F, Staff H, and Staff I, conducted on [redacted], revealed that Staff A, Staff F, Staff H, and Staff Idid not have evidence that they completed a two-hours ECC training within six months of employment. Staff A was hired on [redacted]. Staff F was hired on [redacted]. Staff H was hired on [redacted]. Staff I was hired on [redacted]. During an interview with Staff A, Staff B, and Staff C conducted on [redacted] from 03:20pm through 03:22pm, Staff A, Staff B, and Staff C agreed that Staff A, Staff F, Staff H, and Staff I's employee records did not contain evidence that they had obtained two-hours of ECC training within six months of employment. Class III	AE210		