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
	AL11969122	A. BUILDING: _____ B. WING _____	10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT DANIA BEACH	150 STIRLING RD DANIA BEACH, FL 33004

(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
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the [illegible] are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [illegible] submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain any changes in employment status of all employees within the Agency for Health Care Administration (AHCA) Background	CZ814		

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CZ814	Continued From page 1 Screening Clearinghouse within 10 business days, for 2 of 4 sampled staff, Staff K and Staff L. The findings included: On the Employee Roster was compared to the AHCA Background Screening Clearinghouse Roster. The Roster revealed that the facility had not entered an end date of employment for Staff K (Office Staff) who had a date of hire of . . . . . and who is no longer employed by the facility. On the Employee Roster was compared to the AHCA Background Screening Clearinghouse Roster. The Roster revealed that the facility had not entered the date of employment for Staff L (Maintenance) who had a date of hire of . . . . . and who is still currently employed by the facility. On at 2:54 PM, an interview was conducted with the Marketing Director who confirmed Staff K is not a current employee in the facility and she works in another facility within the management company. The Marketing Director stated that Staff L is currently employed with the facility and there has not been a break in his employment. Unclassified	CZ814		

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A 000	Initial Comments An unannounced Relicensure with Limited Mental Health (LMH), Complaints (#2023000231, #2023001857, #2023005023, #2023005977, #2023006217, #2023009369, #2023011925, #2023014193) and Generator monitoring survey was commenced on [redacted] and concluded on [redacted] at The Residence at Dania Beach. The facility had deficiencies identified at the time of the survey related to the Relicensure, LMH and Complaints (#2023001857, #2023005023, #2023005977 and #2023006217) 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 [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted]. 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 [redacted] 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.	A 025		

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A 025	Continued From page 1 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 independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on interview, record review and observation, the facility failed to address a change in medical and condition for 1 of 1 sampled residents, Resident #1. This failure potentially contributed to Resident #1's by failing to notify the resident's Physician or calling Emergency Services when Resident #1 began to	A 025		

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A 025	Continued From page 2 experience an identifiable change in medical and ˬ condition from his usual medical and ˬ status. Further, this failure has the potential to affect the 110 residents currently residing in the facility if they exhibit a change in medical or ˬ condition. The findings included: A review of the facility's Contacting Resident's Families/Guardians/Healthcare Providers Policy dated ˬ documented the following: It is the policy of this facility to contact the resident's 'Families, guardian and healthcare providers in the event of an emergency or change in physical or mental status. The following procedures is implemented: The staff in charge of the operation of the facility at any given time will perform the following in the order listed: a. Dial 911 for transfer to the nearest hospital in the case of an emergency. b. Contact the resident's Health Care provider (Physician). c. Communicate facts of Emergency or change of Status to the family or guardians immediately after 911 is called and Physician has been contacted. A review of the facility Emergency Situations Policy and Procedure dated ˬ documented the following: It is the policy of this facility to contact the resident's family, guardian and healthcare providers in the event of an emergency or change in their physical or mental status and to implement the following procedures:	A 025		

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A 025	Continued From page 3 The Staff in charge of the facility at any given time will perform the following in the order listed below: 1. When a resident has a Medical Emergency the first this to do is dial 911 and report the situation to them. If needed, perform or assist with first aid. Do not give any medication to the resident. On , the facility census was 110 with a capacity of 200 residents. A review of Resident #1's facility file documented that he was admitted to the facility on . A review of the Resident Health Assessment (AHCA form 1823) dated , documents his diagnoses to include right , history of falling, , Type 2 , unspecified , and . Resident #1's Resident Health Assessment (AHCA form 1823) also documented his status as alert with periods of , and required supervision with ambulation (walker), bathing, , grooming, toileting and transfer. In an interview conducted with Resident #27 on at 12:32 PM, he stated to this surveyor that he knew Resident #1, and that Resident #1 was having problems with his on (no time provided) and the Certified Nursing Assistant (CNA) told him to go lay down (could not remember the staff or the time of the encounter). He stated Resident #1 was sent to the hospital the next day and he . In an interview conducted with Medication	A 025		

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A 025	Continued From page 4 Technician (MT) Supervisor Staff E on at 2:51 PM, she stated she serves as the Director of Nurses for the facility. She also stated that when a resident is in the Memory Care Unit (MCU) as was Resident #1, she knows their names, but does not know anything about the residents as that would be MCU Coordinator Staff D's job. In an interview conducted with MCU Coordinator Staff D on at 3:19 PM, she stated to this surveyor that she is in charge of the MCU and oversees staff in the unit. She stated she works from 8:30 AM to 4:30 PM and was familiar with Resident #1. She stated when Resident #1 came to the facility he ambulated with a walker and always had a problem with his . She stated he tired easily, would lose his breath, but he was not on . She stated she worked her 8:00 AM to 4:30 PM shift on and left for the day when her shift ended at 4:40 PM. She stated MT Staff J telephoned at approximately 5:30 PM and informed her that Resident #1 was not feeling well. She stated she asked MT Staff J if she had contacted his wife, and MT Staff J informed her that she had informed the wife prior to their call, and that she said she was coming to the facility but never did. No one assessed the health condition of the resident, no medical interventions were provided, and neither 911 nor the resident's Physician was called. MCU Coordinator Staff D also stated in the interview conducted on at 3:19 PM, that Resident #1's wife always said to call her first before sending him to the hospital because she prefers that he go to (their preferred hospital). She stated sometimes Resident #1's wife would say do not send him to the hospital because it is	A 025		

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A 025	Continued From page 5 always the same problem with his . She further stated that Resident #1 was not experiencing any issues prior to her leaving the facility after her shift ended at 4:30 PM on , and that she observed Resident #1 to be normal throughout the day on . MCU Coordinator Staff D further stated in an interview on at 3:24 PM, that when she arrived at the facility to begin her shift on , she went into Resident #1's room around 8:30 AM and noticed he was not breathing, so she called 911. She stated she spoke with the overnight shift Home Health Aide (HHA) Staff F and HHA Staff N who had worked the 11:00 PM to 7:00 AM shift, and HHA Staff F stated they checked on Resident #1 during the night and he was breathing. MCU Coordinator Staff D stated the morning shift MT Staff C and Certified Nursing Assistant (CNA) Staff M reported for their 7:00 AM to 3:00 PM shift following the previous shift, and when she reported for her shift around 8:30 AM on , MT Staff C informed her that Resident #1 looked like he was not breathing, and she went in to check him. She stated when she went into his room, she did not check him, she just looked at his and called 911 when she did not see it moving. She stated she did not perform , and that no staff on the previous shift, 11:00 PM to 7:00 AM or the arriving 7:00 AM to 3:00 PM shift provided medical interventions, performed , called 911 or the resident's Physician. In a follow-up interview conducted with MCU Coordinator Staff D on at 10:58 AM, she restated to this surveyor that MT Staff J telephoned her around 5:00 PM to 5:30 PM on /3023 to inform her of Resident #1's health	A 025		

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A 025	Continued From page 6	A 025		

status and that only Resident #1's wife was called as they are required to call the family to determine what course of action to take (call 911, send to hospital, etc.). She stated no one called his doctor because his wife always wanted them to call her before they sent him to the hospital. She stated Resident #1 had [illegible] issues and they would call his wife and she would tell them what hospital to send him to. Further, MT Staff J telephoned the wife at approximately 5:25 PM on [illegible] to inform her of his condition and she stated she would be coming to the facility, and that staff were waiting for her to come but she never did. No one assessed the health condition of the resident, no medical interventions were provided, and neither 911 nor the resident's Physician was called.

She further stated during an interview conducted on [illegible] at 11:03 AM, that after being informed on [illegible] at approximately 8:30 AM that Resident #1 was not breathing, she went to his room and observed that his [illegible] was not moving, and immediately called 911. She stated they arrived within 10 minutes, and she provided them with Resident #1's contact information and they called the family. She stated she did not go into the room with them, but they pronounced him [illegible] in his room. No time of the pronouncement was available or provided. She also stated there is an Automated External Defibrillator ([illegible]) device in the unit (as observed by this surveyor on the South wall by the receptionist desk), but it was not used on Resident #1.

In an interview conducted with MT Staff J on [illegible] at 4:17 PM, she stated to this surveyor that she was checking on Resident #1 during her 3:00 PM to 11:00 PM shift on [illegible] and that he was not feeling well. She

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A 025	Continued From page 7	A 025		

stated when she went to give Resident #1 his evening medications around 5:15 PM, that is when she learned he was not feeling well, so she did not give him any medication and called his wife. She stated she asked Resident #1's wife if she wanted him to go to the hospital and she never said anything, just that she was coming to the facility. She stated after the call to Resident 1's wife, she telephoned her supervisor, MCU Coordinator Staff D, around 5:30 PM to inform her that Resident #1 was not feeling well. MCU Coordinator Staff D asked her if she had spoken to the wife, and she said yes, and that the resident's wife stated she would be coming to the facility but did not during her shift. She stated 911 was not called because she was waiting for his wife to come to the facility. She stated that it was her husband, and there was nothing she could do. She stated she checked the resident's , , and it was very, very low. She also stated that when she touched him, he was very , and that he had a , , but he was really . She stated she informed the night shift staff of his condition and to check on him because he was not feeling well. However, she nor any other staff assessed Resident #1's health condition, provided medical interventions, nor called 911 or the resident's Physician during the 3:00 PM to 11:00 PM shift.

In an interview conducted with the Marketing Director, who was acting in the absence of the Administrator on at 3:17 PM, she stated she did not think any follow-up training was done after the passing of Resident #1. There was no documentation provided to this surveyor during the survey, that the facility conducted an investigation regarding the incident with Resident #1.

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A 025	Continued From page 8 In an interview on . . . . . at 11:07 AM conducted with HHA Staff P, she stated to the surveyor that she works the 3:00 PM to 11:00 PM shift, as she did on . She stated during her shift that Resident #1 was . . . and not moving. She stated she provided comfort to the resident, propped a pillow behind his . . . so he could eat his dinner. She stated she left the room and MT Staff J stayed behind administering medication. She stated during her shift she and MT Staff J were concerned about the health of Resident #1 as he did not look or feel well. She stated MT Staff J made the decision to call the MCU Coordinator Staff D at approximately 9:00 PM. She stated the MCU Coordinator Staff D informed MT Staff J to call Resident #1's wife because staff is not allowed to call 911, and family members are responsible for their family. No one assessed the health condition of the resident, no medical interventions were provided, and neither 911 nor the resident's Physician was called. In an interview conducted with MT Staff C on . . . . . at 11:18 AM, she stated to this surveyor that she works the 7:00 AM to 3:00 PM shift in the MCU and provides medication and direct care to residents. She stated Resident #1 was compliant with his medications, ate very good, and on she observed him at breakfast and lunch in the MCU dining room and he ate very good at both meal settings. She stated after the lunch meal, he went to his room and went to sleep. She stated she last saw Resident #1 on the day of . . . . . around 2:00 PM when she was doing her rounds. She stated he was asleep and breathing, so she did not bother him. She stated when she came in the next morning on to begin her shift at 7:00 AM, the midnight shift told her Resident #1	A 025		

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had . . . . She stated she called 911 and the paramedics came around 7:20 AM to 7:30 AM. She stated when MCU Coordinator Staff D came into work, she informed her of Resident #1's . . . . and that the family came to the facility (no time provided). She stated the facility's policy is to call 911 when a resident appears to be having medical issues. However, no one assessed the health condition of the resident, no medical interventions were provided, and neither 911 nor the resident's Physician was called during the 11:00 PM to 7:00 AM shift.

In an interview on at 11:30 AM conducted with HHA Staff O, she stated to the surveyor that on she worked the 11:00 PM to 7:00 AM shift in the MCU where Resident #1 resided. She stated Resident #1 was . . . . during her shift, and that he told the staff, HHA Staff F, HHA Staff N and her, that he was not feeling well. She stated Resident #1 kept . . . . and that at 5:00 AM on she gave him a shower. She stated they were informed by MCU Coordinator Staff D not to call 911, they are to call the family prior to calling 911. Staff stated that they attempted to call the wife, but the wife did not come. She stated neither she nor HHA Staff F assessed the health condition of the resident, no medical interventions were provided, and neither 911 nor the resident's Physician was called during the 11:00 PM to 7:00 AM shift.

On at 1:09 PM, a telephone call was made to the Administrator Staff A who was not at the facility as she was on vacation. She stated Resident #1's family was very involved, especially his wife, who would take him to his doctor and provide him with basic assistance. She stated Resident's #1 was in a wheelchair and was

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A 025	Continued From page 10 compliant with his medications. Administrator Staff A stated she was in the facility on . . . . . the day Resident #1 complained of being sick but did not see the resident. She stated MCU Coordinator Staff D told her that the next day on , that he was not feeling good and that she spoke to his wife regarding it. She stated there was nothing major to the point that they would have to call 911 or take further steps. She stated MCU Coordinator Staff D called the wife the day before on . . . . . to explain that he was complaining about not feeling well, but that she was not sure of what the complaint was. She stated she left the facility on at 5:00 PM, and she did not get a call from anyone that day regarding the resident. She stated MCU Coordinator Staff D called her the next morning on around 8:00 AM on her way to work and informed her that the resident had expired. She stated 911 came and they were still at the facility when she arrived. She stated she did not go into Resident #1's room, but the paramedics pronounced him . . . . inside his room. There was no evidence provided that the facility did any investigation into the breakdown in communication between staff and the resident's Physician when Resident #1 was expressing he was not feeling well, thereby not following their policy to notifiy a resident's Physician when there was a change in condition. Administrator Staff A also stated in the telephone interview that the facility's policy is to call 911 if someone , if someone is in Resident #1's situation, when someone dies in their sleep, 911 is called right away. If someone is in huge , the staff cannot wait for a family member to be called, they should call 911. And if any other immediate attention is needed, staff are to call 911, and first it is 911, and then the family.	A 025		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT DANIA BEACH	150 STIRLING RD DANIA BEACH, FL 33004

(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 11 However, she stated in Resident #1's specific situation he did not require 911 the day before on . She stated that if someone complains that their hurts, they will call the family. She stated that in Resident #1's case, first 911, but he in his sleep. She stated as such it was not a situation where 911 needed to be called because he was feeling fine. She stated there was no assessment done because he was feeling normal. However, in interviews conducted with this surveyor, MCU Coordinator Staff D, HHA Staff O, MT Staff C, HHA Staff P, MT Staff J, CNA Staff M and Resident #27, all stated Resident #1 was not feeling well on and no one called 911 or notified his Physician of the change in his health status. Administrator Staff A further stated in the telephone interview on at 1:16 PM, that MCU Coordinator Staff D is responsible for calling 911 in the MCU, and MT Supervisor Staff E is responsible for doing so on the Assisted Living side. She stated if she is at the facility, she will call as well. She also stated that the MT Supervisor can call. She further stated that whatever staff is with the resident should make the 911 call. She stated in Resident #1's case, was not provided as he had already passed. She stated she spoke with HHA Staff F who was taking care of Resident #1 the night prior to his passing and HHA Staff F informed her that when she went to the room to change him while doing her rounds that morning, she noticed he was , she checked his , and she called 911. She stated staff are required to check on residents every 2 hours, and that HHA Staff F was checking on Resident #1 and all the residents through the night, every 2 hours. She further stated HHA Staff F never noticed anything out of the norm and that Resident #1 was just	A 025		

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A 025	Continued From page 12	A 025		

sleeping. It was in the morning when HHA Staff F was trying to change him that she noticed he was . . . . She stated HHA Staff F did not provide any medical assistance because he was . This surveyor asked who made the determination he was . She said the employee HHA Staff F determined he was . . . . . A review of HHA Staff F's facility file and documents revealed Staff F is a Home Health Aide and not a licensed medical professional.

In a telephone interview conducted on at 11:46 AM with CNA Staff M, she stated to this surveyor that she worked the 7:00 AM to 3:00 PM shift the day prior to Resident #1's passing on , and that he was in bed most of the day, did not eat, and he had . . . . . She stated he did not come out of his room for his meal, so she took breakfast (eggs/pancakes/juice) to him in his room, and he did not want it. She stated she tried to make him drink the juice, but he did not want it. She stated that when he did not eat, she made him crackers and hot tea. She stated he took the tea and not crackers. She stated she checked on him again at lunch time on and he did not want the lunch, so she made him some noodle soup which he had in his room. She stated he took a few bites and drank some juice. She stated she checked on him again at 3:00 PM and he was still in bed. She stated she told him to try and eat and he said he would. She stated he was kind of weak and just wanted to stay in bed. She stated that when she arrived for work at the facility the next morning on . . . . . around 6:00 AM, he was already . She stated she is not aware of anyone assessing the health condition of the resident, providing medical interventions, calling 911 or the resident's Physician during the 11:00 PM to 7:00 AM shift, the shift during which Resident #1 .

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A 025	Continued From page 13 Nobody notified the resident's Physician or called 911 regarding Resident #1's change in condition on all 3 shifts. A review of Resident #1's facility file, documents and Charting Notes did not reveal any documentation regarding Resident #1's health status or care provided. Observation was made of only a single entry on his Charting Notes dated . There was no documentation or information arising from interviews that facility staff assessed the health condition of the resident, provided medical interventions, called 911 or the resident's Physician on when he was exhibiting a change in medical condition or the early morning of when Resident #1 subsequently , after experiencing a change in medical condition since the previous day. Class I	A 025		
A 052	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication	A 052		

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A 052	Continued From page 14	A 052		

name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change.
(c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her .
(d) Applying , medications.
(e) Returning the medication container to proper storage.
(f) Keeping a record of when a resident receives assistance with self-administration under this section.
(g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the .
(4) Assistance with self-administration of medication does not include:
(a) Mixing, , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed.
(b) The preparation of syringes for injection or the administration of medications by any injectable route.
(c) Administration of medications by way of a tube inserted in a , of the body.
(d) Administration of , preparations.
(e) The use of irrigations or debriding agents

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A 052	Continued From page 15 used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident	A 052		

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A 052	Continued From page 16	A 052		

to take medications as prescribed.
(c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container.
(d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record.
(e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed:
1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility,
2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record,
3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or
4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging.
(f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S.
(g) As used in Section 429.256(4)(h), F.S., the

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A 052	Continued From page 17 terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation and interview the facility failed to follow appropriate steps for assistance with the self-administration of medication, by orally advising the name and dosage of the medication and verbally prompting the resident to take medications as prescribed for 5 out of 5 sampled residents, Resident #13, Resident #14, Resident #15, Resident #19, and Resident #20. The findings included: During a medication observation pass with Medication Technician (MT) Staff C on the following was observed. I. In an observation conducted on at 12:05 PM during medication pass, MT Staff C took medication from its previously dispensed, properly labeled container from the medication cart and failed to announce in the presence of the resident, the name of the medication intended for Resident #13, , 300 milligrams (mg) as prescribed, by orally advising the resident of the medication name and dosage, opening the container, removing the prescribed amount of medication from the container, and closing the container. II. In an observation conducted on at 12:11 PM during medication pass, MT Staff C	A 052		

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A 052	Continued From page 18 took medication from its previously dispensed, properly labeled container from the medication cart and failed to announce in the presence of the resident, the name of the medication intended for Resident #19, , 1 mg as prescribed, by orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. III. In an observation conducted on at 12:15 PM during medication pass, MT Staff C took medication from its previously dispensed, properly labeled container from the medication cart and failed to announce in the presence of the resident, the name of the medication intended for Resident #15, , 300 mg as prescribed, by orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. . In an observation conducted on at 12:18 PM during medication pass, MT Staff C took medication from its previously dispensed, properly labeled container from the medication cart and failed to announce in the presence of the resident, the name of the medication intended for Resident #14, , -Levodop 25-100 mg as prescribed, by orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. V. In an observation conducted on at 12:21 PM during medication pass, MT Staff C took medication from its previously dispensed, properly labeled container from the medication cart and failed to announce in the presence of the	A 052		

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A 052	Continued From page 19 resident, the name of the medication intended for Resident #20, , 500 mg as prescribed, by orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. On at 2:24 PM, an interview was conducted with the Marketing Director. She acknowledged the findings. Class III	A 052		
A 054	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	A 054		

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A 054	Continued From page 20 each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to immediately update the Medication Observation Record (MOR) each time assistance with the self-administration of medications was conducted for 5 out of 5 sampled residents, Resident #13, Resident #14, Resident #15, Resident #19, and Resident #20. The findings included: In an observation conducted on from 12:05 PM to 12:21 PM during medication pass observation with Medication Technician (MT) Staff C, MT Staff C walked from the medication cart station of the Memory Care Unit main entrance hallway carrying medication cups to Resident #13, Resident #14, Resident #15, Resident #19 and Resident #20. MT Staff C failed to immediately update the MOR each time the medication was offered to each resident. At approximately 12:30 PM, MT Staff C walked to the medication cart station to update the MOR for Resident #13, Resident #14, Resident #15, Resident #19, and Resident #20. On at 2:54 PM, an interview was conducted with the Marketing Director who acknowledged the findings.	A 054		

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A 054	Continued From page 21 Class III	A 054		
A 081	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) 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.	A 081		

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A 081	Continued From page 22 (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 control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , , 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 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	A 081		

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A 081	Continued From page 23 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 policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that all staff completed the	A 081		

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A 081	Continued From page 24 Preservice Orientation prior to interacting with residents for 1 out of 4 sampled employees, Staff G. The findings included: Review of the employee record for Home Health Aide (HHA) Staff G revealed a date of hire of . . . . . as a direct Caregiver to work the 3:00 PM to 11:00 PM shift. Further review of the employee record revealed that HHA Staff G did not have evidence of completion of the Preservice Orientation in her employee record prior to interacting with residents. On at 1:04 PM, during an interview conducted with the Marketing Director, she stated that all the documents that are in the employee files is all the training that the employees had that she knows of. The documentation had initially been requested on . . . . . at 4:03 PM, and then again on at 1:05 PM. No further documentation was provided. Class III	A 081		
A 084	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfillment of this requirement must	A 084		

Agency for Health Care Administration

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	AL11969122	A. BUILDING: _____ B. WING _____	10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT DANIA BEACH	150 STIRLING RD DANIA BEACH, FL 33004

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A 084	Continued From page 25 meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, dosage forms, and and dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires	A 084		

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A 084	Continued From page 26 judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with syringes that are prefilled with the proper dosage by a pharmacist and , that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection; i. Assist with ; j. Use a to perform testing; k. Assist residents with and continuous positive airway pressure (CPAP) devices, excluding the titration of the levels; l. Apply and remove stockings and hosiery; m. Placement and removal of , bags, excluding the removal of the , or manipulation of the site; and, n. Measurement of rate, temperature, and , rate. (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education	A 084		

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A 084	Continued From page 27 training may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that all staff that assist residents with the self-administration of medications had completed the annual medication training for 2 out of 4 sampled employee records reviewed, for Staff E and Staff F. The findings included: Review of Staff E's employee record revealed a hire date of [redacted] as a Medication Technician (MT). Further review of her record revealed 6-hours of training on assistance with the self-administration of medications dated	A 084		

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A 084	Continued From page 28 . . . . There was no evidence of documentation of any annual 2 hour training on the assistance with self-administration of medication training in 2022 or 2023. Review of MT Staff F's employee record revealed a hire date of . . . . . Further review of her record revealed 6-hours of training on assistance with the self-administration of medications dated . There was no evidence of documentation of any annual 2 hour training on the assistance with self-administration of medication training from 2019 through 2023. During an interview conducted with the Marketing Director of the facility on at 1:05 PM, she stated she was unsure why the annual medication training was not in the employee files. Class III	A 084		
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, 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:	A 152		

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A 152	Continued From page 29 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observations, interview and record review, the facility failed to ensure a safe, clean and sanitary environment, free from pests for 10 of 10 residents observed (Residents #17, #27, #28, #29, #30, #31, #32, #33, #34, #36 and #38); and failed to ensure that all existing architectural, mechanical, electrical and structural systems are maintained in good working order. The findings included: During the survey of the facility on , this surveyor conducted a investigation with the Florida Department of Health (DOH) relative to bedbugs and pests (roaches). During the investigation, the following observations were	A 152		

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A 152	Continued From page 30 made: During observation of [redacted] on [redacted] at 10:43 AM, observation was made of live roaches crawling on the resident's breakfast that was placed on a dining cart. Observation was also made of live bedbugs on the bed located on the southeast wall of the room. During observation of Resident #27's room at 10:53 AM, observation was made of bedbugs on the resident's bed, and roaches crawling on the floor of the room. During observation of Resident #28's [redacted] at 11:16 AM, live bedbugs were observed on the resident's pillow on her bed. In an interview conducted with Resident #28 on [redacted] at 11:17 AM, she stated she had been bitten by bedbugs. She requested this surveyor look at her [redacted], which revealed redness suggesting irritation from some outside source, which she stated was the result of bedbug bites. During observation of Resident #29's [redacted] at 11:26 AM, observation was made of bedbugs on the resident's bed and the baseboards behind her bed. During observation of Resident #30's [redacted] at 11:52 AM, observation was made of [redacted] bedbugs on the resident's bed located on the right side of the room. In an interview conducted with the resident during the observation, she stated her side of the room had been treated, but not her roommate's side. During observation of Resident #31's room at 12:06 PM, observation was made of live roaches crawling on the southeast wall of the room.	A 152		

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A 152	Continued From page 31 Observation also revealed a toaster, small half sized refrigerator, and , - plugged into a surge protector; all three appliances were on the floor of the room. This surveyor moved the toaster and roaches ran from the inside from under the toaster (Photographic and video evidence obtained). During observation of Resident #32's room at 12:08 PM, observation was made of live bedbugs on both residents' beds. In an interview conducted with Resident #36 on at 12:09 PM, he stated the facility sprays when residents complain. During observation of Resident #33's room at 12:16 PM, observation was made of bedbugs on the resident's bed, and roaches on the floor near the bed. During observation of on , this surveyor made an observation of the bathroom which revealed a sink cabinet with the bottom sunk in, a split and , and the cabinet in disrepair (Photographic evidence obtained). In an interview conducted with the resident on at 11:43 AM, he stated he was given a new mattress 2 days ago because he was being bitten by bedbugs so much. The resident asked this surveyor to look at his , which revealed scale-like rashes which he says came from bedbug bites. He further stated the facility does not provide treatment for the condition resulting from the bedbug bites During observation of on , observation was made by this surveyor of the bathroom, which revealed a sink cabinet whose base was damaged and the shower stall tile at the bottom of the ridge was missing.	A 152		

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A 152	Continued From page 32 During an interview with the Memory Care Unit Supervisor on . . . . . at 10:16 AM, she confirmed a tree in the middle of the patio has been there since , ... An observation by this surveyor revealed the tree . . . was obstructing the resident pathway in the courtyard (Photographic evidence obtained). During an observation of on at 10:22 AM, this surveyor made an observation of the resident's bed sheet with tears, ... -like, and bathroom with a broken shower (Photographic evidence obtained). In an interview conducted with Resident #38 in . . . . on . . . . . at 11:52 AM, he stated he is being bitten by bedbugs at night and showed this surveyor reddish rashes and bumps on his right underarm and . . . which he stated is a result of being bitten by bedbugs. During an interview with Resident #17 on at 1:10 PM, it was stated that a broken doorknob lock had been broken for a while (Photographic evidence obtained). On at 2:54 PM, an interview was conducted with the Marketing Director. She stated that the Administrator was out of the country at this time. She acknowledged the findings and had nothing further to report. On , the DOH conducted a follow up reinspection to their visit conducted on . The results were 'Unsatisfactory' with a reinspection date slated for . . . . . . Review of the DOH follow up Inspection Report dated at 12:52 PM documented -	A 152		

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A 152	Continued From page 33 'Complaint #(xx-xx-xxxxxx) - AHCA representative stated that there are live roaches/bedbugs in several resident rooms during their annual re-licensing.' Further review of the DOH Inspection Report dated documented under 'General Comments': At time of follow up investigation with maintenance person who escorted inspector to affected rooms. Complaint abated in 5 rooms (105, 220, 517, 522, 524). Roaches and bedbugs found in 27 rooms. Notice of violation still valid. As per maintenance person, pest control service was provided on however no service record provided. Documented under 'Violation Comments': Infestation presence. OBSERVED ROACHES IN # , , 132, 135, 136, 211, 216, 305, 306, 312, 401, 402, 411, Memory Care Dining Room - UNSATISFACTORY. OBSERVED BEDBUGS IN # , , 136, 211, 215, 220, 222, 306, 312, 401, 402, 521 - UNSATISFACTORY. On at 10:15 AM, an interview was conducted with the Branch Manager of (name of pest control company) who stated they do have an account with the facility and they treat the facility several times a month. He confirmed there are active bedbugs in the facility, and he discussed with the Administrator about doing a more aggressive treatment plan but that would require residents to be relocated for several days. He stated he discussed this issue approximately one month ago with the Ownership of the facility to plan on moving residents out of the building to do a more extensive exterminating, but they never followed up with him regarding anything	A 152		

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A 152	Continued From page 34 other then their regular monthly service. Class II	A 152		
A 161	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . . . . . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by Rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section 429.174, F.S., and Rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or	A 161		

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A 161	Continued From page 35 more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity . . . . . to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by Rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to provide evidence of Employee References conducted upon hire for 4 out of 4 sampled staff, Staff A, Staff E, Staff F, and Staff G. The findings included: Review of employee records showed Administrator Staff A with a hire date of . . . . . There was no evidence of documentation of Employee References completed upon hire. Review of employee records showed Home Health Aide (HHA) Staff F with a hire date of . . . . . There was no evidence of documentation of Employee References	A 161		

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A 161	Continued From page 36 completed upon hire. Review of employee records showed HHA Staff G with a hire date of . There was no evidence of documentation of Employee References completed upon hire. Review of employee records showed Medication Technician Staff E with a hire date of . There was no evidence of documentation of Employee References completed upon hire. On at 1:05 PM, the Marketing Director stated she is unaware if the Employee References were completed. She stated that everything that staff has completed is in the staff employee files. Class III	A 161		
A 168	429.24(3)(a) FS; 429.27(7), FS Resident Refund Policy 429.24 (3)(a) . . . The refund policy shall provide that the resident or responsible party is entitled to a prorated refund based on the daily rate for any unused portion of payment beyond the termination date after all charges, including the cost of damages to the residential unit resulting from circumstances other than normal use, have been paid to the licensee. For the purpose of this paragraph, the termination date shall be the date the unit is vacated by the resident and cleared of all personal belongings. If the amount of belongings does not preclude renting the unit, the facility may clear the unit and charge the resident or his or her estate for moving and storing the items at a rate equal to the actual cost to the	A 168		

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A 168	Continued From page 37 facility, not to exceed 20 percent of the regular rate for the unit, provided that 14 days' advance written notification is given. If the resident's possessions are not claimed within 45 days after notification, the facility may dispose of them. The contract shall also specify any other conditions under which claims will be made against the refund due the resident. Except in the case of . . . . or a discharge due to medical reasons, the refunds shall be computed in accordance with the notice of relocation requirements specified in the contract. However, a resident may not be required to provide the licensee with more than 30 days' notice of termination. If after a contract is terminated, the facility intends to make a claim against a refund due the resident, the facility shall notify the resident or responsible party in writing of the claim and shall provide said party with a reasonable time period of no less than 14 calendar days to respond. .... 429.27, FS Property and personal affairs of residents. - (7) In the event of the of a resident, a licensee shall return all refunds, funds, and property held in trust to the resident's personal representative, if one has been appointed at the time the facility disburses such funds, and, if not, to the resident's spouse or adult next of kin named in a beneficiary designation form provided by the facility to the resident. If the resident has no spouse or adult next of kin or such person cannot be located, funds due the resident shall be placed in an interest-bearing account, and all property held in trust by the facility shall be safeguarded until such time as the funds and property are disbursed pursuant to the Florida Probate Code. Such funds shall be kept separate from the funds and property of the facility and	A 168		

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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 168	Continued From page 38 other residents of the facility. If the funds of the resident are not disbursed pursuant to the Florida Probate Code within 2 years after the resident's , the funds shall be deposited in the Health Care Trust Fund administered by the agency. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to provide a refund to 1 of 1 sampled residents reviewed for refunds, Resident #3. The findings included: A review of facility and resident records revealed that Resident #3 moved into the facility on . On , Resident #3 was transferred out to the hospital and never returned to the facility and was subsequently discharged (date not provided). The family was informed that Resident #3 was entitled to and would receive a refund for the balance of the time she was charged but not in the facility. In an interview conducted with Medication Technician Supervisor Staff E on at 11:53 AM, she stated Resident #3 was only at the facility a few days. She stated Resident #3 came in to the facility and went to the hospital and never came . In an interview conducted with the Administrator on at 4:16 PM, she stated Resident #3 was due a refund of $638.71 and provided this surveyor the email communication dated documenting the conversation she had with their Corporate office. She stated she would contact the office to gather information as to the status of the refund and contact the family	A 168		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969122	A. BUILDING: _____ B. WING _____	10/10/2023

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A 168	Continued From page 39 as well to verify receipt of the refund. In an interview conducted with the Administrator on at 4:27 PM, she stated she spoke with the family a few minutes earlier and was informed by them they had not received the refund. The Administrator stated the check was processed and maybe it got lost in the mail. The refund had not been received by the family during the time of the survey. Class III	A 168		
AL243	429.075(1) FS; 59A-36.011(9) FAC LMH - Training 429.075 (1) To obtain a limited mental health license, a facility must hold a standard license as an assisted living facility, must not have any current uncorrected violations, and must ensure that, within 6 months after receiving a limited mental health license, the facility administrator and the staff of the facility who are in direct contact with mental health residents must complete training of no less than 6 hours related to their duties. This designation may be made at the time of initial licensure or relicensure or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with this part, part II of chapter 408, and applicable rules. This training must be provided by or approved by the Department of Children and Families. 59A-36.011 (9) LIMITED MENTAL HEALTH TRAINING. (a) Pursuant to section 429.075, F.S., the administrator, managers and staff, who have	AL243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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AL243	Continued From page 40 direct contact with mental health residents in a licensed limited mental health facility, must receive the following training: 1. A minimum of 6 hours of specialized training in working with individuals with mental health diagnoses. a. The training must be provided or approved by the Department of Children and Families and must be taken within 6 months of the facility's receiving a limited mental health license or within 6 months of employment in a limited mental health facility. b. Training received under this subparagraph may count once for 6 of the 12 hours of continuing education required for administrators and managers pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 2. A minimum of 3 hours of continuing education, which may be provided by the ALF administrator, online, or through distance learning, biennially thereafter in subjects dealing with one or more of the following topics: a. Mental health diagnoses; and, b. Mental health treatment such as: (I) Mental health needs, services, behaviors and appropriate interventions; (II) Resident progress in achieving treatment goals; (III) How to recognize changes in the resident's status or condition that may affect other services received or may require intervention; and, ( ) Crisis services and the procedures. 3. For administrators and managers, the continuing education requirement under this subsection will satisfy 3 of the 12 hours of continuing education required biennially pursuant to section 429.52(5), F.S., and subsection (1) of this rule.	AL243		

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AL243	Continued From page 41 4. Administrators, managers and direct contact staff affected by the continuing education requirement under this subsection shall have up to 6 months after the effective date of this rule to meet the training requirement. (b) Administrators, managers and staff do not have to repeat the initial training should they change employers provided they present a copy of their training certificate to the current employer for retention in the facility's personnel files. They must also ensure that copies of the continuing education training certificates, pursuant to subparagraph (a)2. of this subsection, are retained in their personnel files. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility that holds a Limited Mental Health (LMH) specialty on their license, failed to ensure staff receive the 6 hour LMH training and/or 2 hours of update training every 2 years for 4 out of 4 sampled staff, Staff A, Staff E, Staff F, and Staff G. The findings included: Review of the facility posted license indicates the facility holds a Limited Mental Health specialty on their license. Review of employee records showed Administrator Staff A with a hire date of . There was no documentation Administrator Staff completed 6 hours of LMH training within 6 months of hire in her file. Review of employee records showed Medication Technician Supervisor Staff E with a hire date of . There was documentation of	AL243		

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AL243	Continued From page 42 completion of 6 hours of LMH training within 6 months of her hire on in the file that had expired as of with no evidence of update training every 2 years. Review of employee records showed Home Health Aide (HHA) Staff F with a hire date of . There was no documentation HHA Staff F completed 6 hours of LMH training within 6 months of hire in her file. Review of employee records showed HHA Staff G with a hire date of . There was no documentation HHA Staff G completed 6 hours of LMH training within 6 months of hire in her file. On at 1:05 PM, the Marketing Director stated she was unaware if the training was completed. She stated that everything that staff has completed is in the staff employee files. Class III	AL243		