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
	AL11963775	A. BUILDING: _____ B. WING _____	11/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAM HOME # 2 INC	1045 WEST 2 AVENUE HIALEAH, FL 33010

(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 re-licensure survey, with a limited mental health component, was conducted at Adam Home #2, Inc on and concluded . The provider had deficiencies identified at the time of the visit.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of ... or ... or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or ... The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making ... for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of	A 025		

AHCA Form 3020-0001

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

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A 025	Continued From page 1 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 observation, interview and record review, the facility failed to offer personal supervision as appropriate for each resident. The facility also failed to maintain 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 for two out of twelve sampled residents (Resident #1 and Resident #2). Findings included:	A 025		

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A 025	Continued From page 2 On at 10:35 AM, observation showed Resident #1 had a on his left . On at 10:36 AM, Staff B (caregiver) stated that Resident #1 had a black because he got into a fight regarding their clothes with Resident #2, who was in the hospital. On at 11:07 AM, the Administrator stated that the incident happened on at about 9:00 PM. On , the night shift staff informed her that Resident #1 was upset because Resident #2 lay down on his bed and when he said something to Resident #2, Resident #2 punched him. The Administrator further stated that the following day , the medical provider went to the facility to check on Resident #1's . Additionally, the Administrator stated that Resident #2 was transferred to the hospital the next day because he was agitated and refusing his medications. On at 3:18 PM, during a telephone interview with Staff C (night shift caregiver), she stated that the incident occurred around 11:00 PM and all the residents were in bed. She stated that she heard some noise from Resident #1 and Resident #2's room. She went to see what was going on, and the residents told her that they had an argument because Resident #2 went to the closet and touched Resident #1's clothes. Then, Resident #1 said something to Resident #2, and he punched Resident #1 in his . Staff C further stated that she only noticed some redness in Resident #1's , so she put him some ice on it. She stated she did not call the ambulance or the police because the residents were already in bed. She did not see any , so she thought it was not necessary. Staff C stated that she did not call the administrator because she did not	A 025		

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A 025	Continued From page 3 consider it was an emergency, and soon after, the residents went to sleep fine. Review of Resident #1's health assessment completed [illegible] showed medical history and diagnoses of [illegible], and [illegible]. The resident needed supervision with ambulation and assistance with the self-administration of medication. Review of hospital records received showed that on [illegible] Resident #2 was sent to emergency room for evaluation due to reported aggressive behavior and extreme [illegible], bizarre and erratic behavior. [Resident #2] appeared to be very [illegible] with disorganized thought process. Review of Resident #2's record revealed progress notes dated [illegible], translated from Spanish, "Sent resident to the hospital because he is refusing the medications (Se mando al residente para el hospital ya que esta rehusando a los medicamentos)." There were no additional notes regarding Resident #2 aggression toward Resident #1. Review of Resident #2's health assessment completed [illegible] showed medical history and diagnoses of [illegible] prostatic [illegible], and [illegible] destructive [illegible]. The resident needed supervision with ambulation, bathing, [illegible], eating, self-care (grooming), toileting, and transferring; and needed assistance with the self-administration of medication. Class II	A 025		

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A 030 SS=I	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:	A 030		

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A 030	Continued From page 5 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident . . . . . , neglect, and . . 6. Administrative and housekeeping schedules and requirements; 7. . . . . control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States	A 030		

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A 030	Continued From page 6 as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.	A 030		

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A 030	Continued From page 7 (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care . , , ..., and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally . . , ... , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes	A 030		

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A 030	Continued From page 8 in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida.	A 030		

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A 030	Continued From page 9 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated [illegible] or [illegible] under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a safe and decent living environment, free from and neglect for one out of twelve sampled residents (Resident #1). Resident #1's roommate assaulted him and caused him a black [illegible]. Findings included: On [illegible] at 10:35 AM, observation showed Resident #1 had a in his left [illegible]. On at 10:36 AM, Staff B (caregiver) stated that Resident #1 had a black [illegible] because he got into a fight regarding their clothes with Resident #2 who was in the hospital.	A 030		

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A 030	Continued From page 10 On [redacted] at 11:07 AM, the Administrator stated that the incident happened on at about 9:00 PM. On [redacted], the night shift staff informed her that Resident #1 was upset because Resident #2 lay down on his bed and when he said something to Resident #2, he punched him. The Administrator further stated that until the following day [redacted], the medical provider went to the facility to check on Resident #1's [redacted]. Additionally, the Administrator stated that Resident #2 was transferred to the hospital the next day [redacted] because he was agitated and refusing his medications. On [redacted] at 3:18 PM, during a telephone interview with Staff C (night shift caregiver), she stated that the incident occurred around 11:00 PM and all the residents were in bed. She stated that she heard some noise from Resident #1 and Resident #2's room. She went to see what was going on, and the residents told her that they had an argument because Resident #2 went to the closet and touched Resident #1's clothes. Then, Resident #1 said something to Resident #2, and he punched Resident #1 in his [redacted]. Staff C further stated that she only noticed some redness in Resident #1's [redacted], so she put him some ice. She did not call the ambulance or the police because the residents were already in bed. She did not see any [redacted], so she thought it was not necessary. Staff C stated that she did not call the administrator because she did not consider it was an emergency, and soon after, the residents went to sleep fine. Personnel record review for Staff C showed she completed 1 hour of training on resident rights and recognizing and reporting [redacted], neglect and [redacted] on [redacted].	A 030		

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A 030	Continued From page 11 On at 1:02 PM, during a telephone interview with the advanced practice registered nurse (APRN), he stated that he received a call from the facility on for Resident #1 who received a punch from another resident. The APRN further stated that Resident #1 had a hematoma in his left . Review of Resident #1's health assessment completed showed medical history and diagnoses of , , ( ), and . The resident needed supervision with ambulation and assistance with the self-administration of medication. Review of hospital records received showed that on Resident #2 was sent to emergency room for evaluation due to reported aggressive behavior and extreme , bizarre and erratic behavior. [Resident #2] appeared to be very with disorganized thought process. Furthermore, the records showed Resident #2 had a previous admission to the hospital on due to disorganized and aggressive behavior. After being discharged from the hospital on , Resident #2 was admitted to the facility. On at 12:33 PM, during a second visit to the facility, observation showed Resident #2 seated on the patio and Resident #1 was seated on a chair at a short distance away. On at 1:07 PM, the Administrator stated that Resident #2 returned from hospital on . The Administrator stated that her intervention was to change the residents' rooms and tell the staff to be aware of them. In case of a fight, the staff would intervene by separating them	A 030		

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A 030	Continued From page 12 and take them to another place. Regarding the admission of Resident #2 to the facility, the Administrator stated that Resident #2 came from the hospital and was referred by the psychiatrist. The Administrator said that she did not know Resident #2 was aggressive. She even called the previous facility, and they told her the reason they could not take Resident #2 was because all the beds were full. On at 11:46 AM, during a telephone interview with the Manager at the previous facility where Resident #2 lived, she stated that Resident #2 was sent to the hospital on for being aggressive. She further stated that the facility served the resident a 45 days' notice on to because Resident #2 did not follow the facility policies, and he did not provide a safe environment. Resident #2 tried to provoke other residents, yelled, and threatened them. The Manager further stated that she did not recall having received a call from a facility administrator inquiring about the reason Resident #2 was not going to be readmitted. Class II	A 030		
A 077 SS=D	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120	A 077		

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A 077	Continued From page 13 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least [illegible]; 2. If employed on or after [illegible], have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after	A 077		

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	AL11963775	A. BUILDING: _____ B. WING _____	11/27/2023

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A 077	Continued From page 14 becoming employed as a facility administrator. Administrators who attended core training prior to [redacted], are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the [redacted] of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile [redacted] of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities.	A 077		

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A 077	Continued From page 15 (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to appoint in writing a separate manager for the facility. Findings included: A review of the Florida Health Finder database showed the Administrator was listed as the administrator of the facility. Review of background screening clearinghouse showed that the Administrator was listed as administrator for three assisted living facilities.	A 077		

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A 077	Continued From page 16 Further review revealed that none of the three facilities had an assigned manager. On at 3:45 PM, the Administrator stated that she would assign a manager. Class III	A 077		
A 079 SS=D	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents — Staff Hours/Week 0-5 — 168 . . — 212 16-25 — 253 26-35 — 294 36-45 — 335 46-55 — 375 56-65 — 416 66-75 — 457 76-85 — 498 86-95 — 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to	A 079		

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A 079	Continued From page 17	A 079		

facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility.
4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night.
5. A staff member who has completed courses in First Aid and ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times.
a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement.
b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and .
6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager.
7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement.
8. The administrator or manager's time may be

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counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule.
9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted.
(b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C.
(c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives.
(d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required.

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A 079	Continued From page 19 Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in	A 079		

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A 079	Continued From page 20 accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards for two out of twelve sampled residents (Resident #1 and Resident #2). Findings included: On at 10:35 AM, observation showed Resident #1 had a in his left . On at 10:36 AM, Staff B (caregiver) stated that Resident #1 had a black because he got into a fight regarding their clothes with Resident #2 who was in the hospital. On at 11:07 AM, the Administrator stated that the incident happened on at about 9:00 PM. On , the night shift staff informed her that Resident #1 was upset because Resident #2 lay down on his bed and when he said something to Resident #2, he punched him. The Administrator further stated that until the following day , the medical provider went to the facility to check on Resident #1's . Additionally, the Administrator stated that Resident #2 was transferred to the hospital the next day because he was agitated and refusing his medications. On at 3:18 PM, during a telephone interview with Staff C (night shift caregiver), she stated that the incident occurred around 11:00 PM and all the residents were in bed. She stated that she heard some noise from Resident #1 and Resident #2's room. She went to see what was going on, and the residents told her that they had an argument because Resident #2 went to the closet and touched Resident #1's clothes. Then, Resident #1 said something to Resident #2, and	A 079		

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A 079	Continued From page 21 he punched Resident #1 in his . Staff C further stated that she only noticed some redness in Resident #1's , so she put him some ice. She did not call the ambulance or the police because the residents were already in bed. She did not see any , so she thought it was not necessary. Staff C stated that she did not call the administrator because she did not consider it was an emergency, and soon after, the residents went to sleep fine. Review of Resident #1's health assessment completed showed medical history and diagnoses of , , , ( ), and . The resident needed supervision with ambulation and assistance with the self-administration of medication. Review of hospital records received showed that on Resident #2 was sent to emergency room for evaluation due to reported aggressive behavior and extreme , bizarre and erratic behavior. THe record stated " [Resident #2] appeared to be very with disorganized thought process." Review of Resident #2's health assessment completed showed medical history and diagnoses of , , prostatic , ( ), , , , and destructive . The resident needed supervision with ambulation, bathing, , eating, self-care (grooming), toileting, and transferring; and needed assistance with the self-administration of medication. Review of the facility's staffing pattern from to revealed that only one	A 079		

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A 079	Continued From page 22 staff member (Staff C) was scheduled to work from 7:00 PM to 7:00 AM for a census of 12 residents. Class III	A 079		
A 165 SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or	A 165		

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A 165	Continued From page 23 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to	A 165		

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A 165	Continued From page 24 disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a preliminary report to the agency within 1 business day after the occurrence of an adverse incident, and a full report within 15 days that include the results of the facility's investigation into the adverse incident. Also, the facility failed to report , neglect, or to the Department of Children and Families. Findings included: On at 10:35 AM, observation showed Resident #1 had a in his left . On at 10:36 AM, Staff B (caregiver) stated that Resident #1 had a black because he got into a fight regarding their clothes with Resident #2 who was in the hospital.	A 165		

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A 165	Continued From page 25 On at 11:07 AM, the Administrator stated that the incident happened on at about 9:00 PM. On , the night shift staff informed her that Resident #1 was upset because Resident #2 lay down on his bed and when he said something to Resident #2, he punched him. The Administrator further stated that until the following day , the medical provider went to the facility to check on Resident #1's . Additionally, the Administrator stated that Resident #2 was transferred to the hospital the next day because he was agitated and refusing his medications. On at 3:18 PM, during a telephone interview with Staff C (night shift caregiver), she stated that the incident occurred around 11:00 PM and all the residents were in bed. She stated that she heard some noise from Resident #1 and Resident #2's room. She went to see what was going on, and the residents told her that they had an argument because Resident #2 went to the closet and touched Resident #1's clothes. Then, Resident #1 said something to Resident #2, and he punched Resident #1 in his . Staff C further stated that she only noticed some redness in Resident #1's , so she put him some ice. She did not call the ambulance or the police because the residents were already in bed. She did not see any , so she thought it was not necessary. Staff C stated that she did not call the administrator because she did not consider it was an emergency, and soon after, the residents went to sleep fine. Review of hospital records received showed that on Resident #2 was sent to emergency room for evaluation due to reported aggressive behavior and extreme , bizarre	A 165		

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A 165	Continued From page 26 and erratic behavior. [Resident #2] appeared to be very with disorganized thought process. Review of the agency incident reporting system (AIRS) showed no incident report for the aggression of Resident #2 toward Resident #1 on . On at 3:42 PM, during a telephone interview, the Administrator confirmed she did not file an incident report nor contacted the Department of Children and Families. Class III	A 165		
A 167 SS=D	59A-36.018 FAC; 429.24 FS Resident Contracts 59A-36.018 Resident Contracts. (1) Pursuant to section 429.24, F.S., the facility must offer a contract for execution by the resident or the resident's legal representative before or at the time of admission. The contract must contain the following provisions: (a) A list of the specific services, supplies and accommodations to be provided by the facility to the resident, including limited nursing and extended congregate care services that the resident elects to receive; (b) The daily, weekly, or monthly rate; (c) A list of any additional services and charges to be provided that are not included in the daily, weekly, or monthly rates, or a reference to a separate fee schedule that must be attached to the contract; (d) A provision stating that at least 30 days written notice will be given before any rate increase; (e) Any rights, duties, or of residents, other than those specified in section 429.28, F.S.;	A 167		

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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 167	Continued From page 27 (f) The purpose of any advance payments or deposit payments, and the refund policy for such advance or deposit payments; (g) A refund policy that must conform to section 429.24(3), F.S.; (h) A written bed hold policy and provisions for terminating a bed hold agreement if a facility agrees in writing to reserve a bed for a resident who is admitted to a nursing home, health care facility, or , , facility. The resident or responsible party must notify the facility in writing of any change in status that would prevent the resident from returning to the facility. Until such written notice is received, the agreed upon daily, weekly, or monthly rate may be charged by the facility unless the resident's medical condition prevents the resident from giving written notification, such as when a resident is comatose, and the resident does not have a responsible party to act on the resident's behalf; (i) A provision stating whether the facility is affiliated with any religious organization and, if so, which organization and its relationship to the facility; (j) A provision that, upon determination by the administrator or health care provider that the resident needs services beyond those that the facility is licensed to provide, the resident or the resident's representative, or agency acting on the resident's behalf, must be notified in writing that the resident must make arrangements for transfer to a care setting that is able to provide services needed by the resident. In the event the resident has no one to represent him or her, the facility must refer the resident to the social service agency for placement. If there is disagreement regarding the appropriateness of placement, provisions outlined in section 429.26(8), F.S., will take effect;	A 167		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963775	A. BUILDING: _____ B. WING _____	11/27/2023

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A 167	Continued From page 28 (k) A provision that residents must be assessed upon admission pursuant to subsection 59A-36.006(2), F.A.C., and every 3 years thereafter, or after a significant change, pursuant to subsection (4), of that rule; (l) The facility's policies and procedures for self-administration, assistance with self-administration, and administration of medications, if applicable, pursuant to rule 59A-36.008, F.A.C. This also includes provisions regarding over-the-counter (OTC) products pursuant to subsection (8) of that rule; and, (m) The facility's policies and procedures related to a properly executed DH Form 1896, (2) The resident, or the resident's representative, must be provided with a copy of the executed contract. (3) The facility may not levy an additional charge for any supplies, services, or accommodations that the facility has agreed by contract to provide as part of the standard daily, weekly, or monthly rate. The resident or resident's representative must be furnished in advance with an itemized written statement setting forth additional charges for any services, supplies, or accommodations available to residents not covered under the contract. An addendum must be added to the resident contract to reflect the additional services, supplies, or accommodations not provided under the original agreement. Such addendum must be dated and signed by the facility and the resident or resident's legal representative and a copy given to the resident or resident's representative. 429.24 FS (1) The presence of each resident in a facility shall be covered by a contract, executed at the time of admission or prior thereto, between the	A 167		

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A 167	Continued From page 29 licensee and the resident or his or her designee or legal representative. Each party to the contract shall be provided with a duplicate original thereof, and the licensee shall keep on file in the facility all such contracts. The licensee may not destroy or otherwise dispose of any such contract until 5 years after its expiration. (2) Each contract must contain express provisions specifically setting forth the services and accommodations to be provided by the facility; the rates or charges; provision for at least 30 days' written notice of a rate increase; the rights, duties, and of the residents, other than those specified in s. 429.28; and other matters that the parties deem appropriate. A new service or accommodation added to, or implemented in, a resident's contract for which the resident was not previously charged does not require a 30-day written notice of a rate increase. Whenever money is deposited or advanced by a resident in a contract as security for performance of the contract agreement or as advance rent for other than the next immediate rental period: (a) Such funds shall be deposited in a banking institution in this state that is located, if possible, in the same community in which the facility is located; shall be kept separate from the funds and property of the facility; may not be represented as part of the assets of the facility on financial statements; and shall be used, or otherwise expended, only for the account of the resident. (b) The licensee shall, within 30 days of receipt of advance rent or a security deposit, notify the resident or residents in writing of the manner in which the licensee is holding the advance rent or security deposit and state the name and address of the depository where the moneys are being	A 167		

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A 167	Continued From page 30 held. The licensee shall notify residents of the facility's policy on advance deposits. (3)(a) The contract shall include a refund policy to be implemented at the time of a resident's transfer, discharge, or . . . (b) If a licensee agrees to reserve a bed for a resident who is admitted to a medical facility, including, but not limited to, a nursing home, health care facility, or , facility, the resident or his or her responsible party shall notify the licensee of any change in status that would prevent the resident from returning to the facility. Until such notice is received, the agreed-upon daily rate may be charged by the licensee. (c) The purpose of any advance payment and a refund policy for such payment, including any advance payment for housing, meals, or personal services, shall be covered in the contract. (4) The contract shall state whether or not the facility is affiliated with any religious organization and, if so, which organization and its general responsibility to the facility. (5) Neither the contract nor any provision thereof relieves any licensee of any requirement or imposed upon it by this part or rules adopted under this part. (6) In lieu of the provisions of this section, facilities certified under chapter 651 shall comply with the requirements of s. 651.055. (7) Notwithstanding the provisions of this section, facilities which consist of 60 or more apartments may require refund policies and termination notices in accordance with the provisions of part II of chapter 83, provided that the lease is	A 167		

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A 167	Continued From page 31 terminated automatically without financial penalty in the event of a resident's or relocation due to , , , , , , , , hospitalization or to medical reasons which necessitate services or care beyond which the facility is licensed to provide. The date of termination in such instances shall be the date the unit is fully vacated. A lease may be substituted for the contract if it meets the disclosure requirements of this section. For the purpose of this section, the term "apartment" means a room or set of rooms with a kitchen or kitchenette and lavatory located within one or more buildings containing other similar or like residential units. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure a contract offered for execution by the resident or the resident's legal representative before or at the time of admission contained the daily, weekly or monthly rate for two out of twelve sampled residents (Resident #1 and Resident #2). Findings included: A review of the facility's admission and discharge log showed that Resident #1 was admitted on and Resident #2 was admitted on . A review of Resident #1's record showed the resident agreement was signed by the resident and the facility administrator on . Further review showed that the rate/fee schedule section was left blank. A review of Resident #2's record showed the resident agreement was signed by the resident	A 167		

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A 167	Continued From page 32 and the facility administrator on . . . . . . Further review showed that the rate/fee schedule section was left blank. On . . . . . at 3:45 PM, the Administrator stated that she forgot to include the rate but would complete it. Class III	A 167		