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
	AL11968847	A. BUILDING: _____ B. WING _____	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIBBON CARE ASSISTED LIVING FACILITY, LL	125 AINSWORH CIR PALM SPRINGS, FL 33461

(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 An unannounced Relicensure and Generator Monitoring survey was conducted on [redacted] at Blue Ribbon Care Assisted Living Facility LLC. The facility had deficiencies identified related to the Relicensure at the time of the survey.	A 000		
A 010	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice,	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968847	A. BUILDING: _____ B. WING _____	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIBBON CARE ASSISTED LIVING FACILITY, LL	125 AINSWORH CIR PALM SPRINGS, FL 33461

(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 010	Continued From page 1 and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . . . . . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968847	A. BUILDING: _____ B. WING _____	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIBBON CARE ASSISTED LIVING FACILITY, LL	125 AINSWORH CIR PALM SPRINGS, FL 33461

(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 010	Continued From page 2 (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and,	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968847	A. BUILDING: _____ B. WING _____	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIBBON CARE ASSISTED LIVING FACILITY, LL	125 AINSWORH CIR PALM SPRINGS, FL 33461

(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 010	Continued From page 3 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968847	A. BUILDING: _____ B. WING _____	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIBBON CARE ASSISTED LIVING FACILITY, LL	125 AINSWORH CIR PALM SPRINGS, FL 33461

(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 010	Continued From page 4 described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to appropriately assess the status of 1 of 4 sampled residents for continued residency, Resident #1, as evidenced by the facility being unaware Resident #1 had developed a The findings included: Review of the facility records revealed the facility did not have any specific Policy and Procedure relating to the criteria and determination of appropriateness for continued residency of residents who develop greater than a Review of the record for Resident #1 revealed an admission date to the facility of . Review of the Resident Health Assessment (AHCA form 1823) for Resident #1 dated , revealed diagnoses to include 's and Resident #1 was identified as having a during the Physician assessment. Further review of the resident's record revealed he was receiving Home Health Agency (HHA) nursing services for care as of for the . On at 11:30 AM, observation was made of the HHA Registered Nurse (RN) arriving to the facility to conduct a routine weekly visit for Resident #1's . During this	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968847	A. BUILDING: _____ B. WING _____	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIBBON CARE ASSISTED LIVING FACILITY, LL	125 AINSWORH CIR PALM SPRINGS, FL 33461

(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 010	Continued From page 5 visit, Resident #1's Physician also arrived to do an assessment of Resident #1's . After his evaluation he stated Resident #1's had progressed to a . He prescribed a new treatment regimen and advised the HHA nursing services to continue coming to the facility twice weekly to perform care. On at 11:45 AM, the Administrator stated in an interview she was not aware of Resident #1's or the HHA role. She revealed she had no knowledge of the and learned today it had progressed to a , therefore she had to make a decision of the continued residency of Resident #1. On at 1:15 PM an interview was conducted with the HHA RN who confirmed Resident #1 started with a in and she had recommended having the Physician examine the for a further assessment. The RN also confirmed she visits Resident #1 twice a week for care and today the Physician reassessed the and restaged it from a to a . The RN stated she recommended a high protein and high calorie diet to aid in healing. On at approximately 1:30 PM, an interview was conducted with the Administrator who reiterated she was not aware of Resident #1's status of having a nor the HHA role in treating the . She further stated she was made aware today during this survey by Resident #1's Physician, that the had worsened to a . Further, she stated she was not sure of Resident #1's appropriateness for continued residency in the facility now he was assessed as having a	A 010		

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
	AL11968847	A. BUILDING: _____ B. WING _____	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIBBON CARE ASSISTED LIVING FACILITY, LL	125 AINSWORH CIR PALM SPRINGS, FL 33461

(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 010	Continued From page 6 Class III	A 010		
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 [illegible] the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical [illegible], 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.	A 054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968847	A. BUILDING: _____ B. WING _____	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIBBON CARE ASSISTED LIVING FACILITY, LL	125 AINSWORH CIR PALM SPRINGS, FL 33461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 054	Continued From page 7 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to update the Medication Observation Records (MOR) immediately each time medications were offered to 4 of 4 sampled Residents (Resident #1, Resident #2, Resident #3 and Resident #4). The findings included: At 10:30 AM on a medication audit and review of the MORs for Resident #1 through Resident #4 was conducted revealing the following: 1) On , Resident #1's , 30 milligram (mg) tab, take 1 tab every 8 hours as needed was not signed off. The medication was punched out on the medication bingo card indicating the medication was used. On the following medications were not signed off on the MOR. The oral medications were observed to have been punched out on the medication bingo card. At 6:00 AM the , gel was not documented as applied to the affected area. At 7:00 AM, the , 40 mg tab before the morning meal and , -Levopdopa tab was not signed off as administered. At 8:00 AM, the 1000 mg tab, 250 mg tab, tab was not documented as administered and the cream was not documented as applied to the affected area. At 9:00 AM, the Diskus inhaler, , 10 mg tab, , 81 mg tab, Azelstine spray, 12.5 mg tab, spray, Losartin 50 mg tab, , 15 mg tab, tab and D2 tab were not	A 054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968847	A. BUILDING: _____ B. WING _____	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIBBON CARE ASSISTED LIVING FACILITY, LL	125 AINSWORH CIR PALM SPRINGS, FL 33461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 054	Continued From page 8 signed off as administered. The application to affected , Nysatin to affected area and Silver cream to affected area were not documented as applied. At 2:00 PM, the 600 mg tab was not signed off as administered. 2) On the following medications were not signed off on the MOR for Resident #2. The oral medications were observed to have been punched out on the medication bingo card. At 7:00 AM, the 150 microgram tab and 25 mg tab was not signed off as administered. At 9:00 AM, the tab, 3.125 mg tab, 75 mg tab, 100 mg tab, 2.5 mg tab, 140 mg tab, 1 mg tab, 40 mg tab, 300 mg tab, 400 mg tab, tab were not signed off as administered. The cream to affected area was not signed off as applied. 3) On the following medications were not signed off on the MOR for Resident #3. The oral medications were observed to have been punched out on the medication bingo. At 9:00 AM, the 81 mg tab, inhalation and D tab were not signed off as administered. 4) On the following medications were not signed off on the MOR for Resident #4. The oral medications were observed to have been punched out on the medication bingo card. At 7:00 AM, the gel application to affected left was not signed off as applied. At 8:00 AM, Tears 2 drops both in the morning were not signed off as instilled.	A 054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968847	A. BUILDING: _____ B. WING _____	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIBBON CARE ASSISTED LIVING FACILITY, LL	125 AINSWORH CIR PALM SPRINGS, FL 33461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 054	Continued From page 9 At 9:00 AM, the . . . , . 5 mg tab, . , 81 mg tab, , - , tab, , 125 mg tab, ... 1 mg tab, ... 100 mg tab, , 50 mg tab, 17 grams powder, . . , ... 40 mg tab, ... 50 mg tab, . . . 2 mg tab, and , 0.5 mg tab were not signed off as administered. During an interview conducted on . . . . . at 10:45 AM with the Administrator, she acknowledged that Resident #1, Resident #2, Resident #3 and Resident #4's MOR's were not signed off right after the medications had been offered to the residents. She further stated Caregiver Staff A becomes overwhelmed and busy and puts off signing off on the MOR's until the end of the day after all her other daily tasks are completed. The Administrator further stated she has told Caregiver Staff A numerous times the correct way to give medications and sign the MOR immediately after administrating, but the staff will not do the correct thing. Class III	A 054		
A 078	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another	A 078		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968847	A. BUILDING: _____ B. WING _____	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIBBON CARE ASSISTED LIVING FACILITY, LL	125 AINSWORH CIR PALM SPRINGS, FL 33461

(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 078	Continued From page 10 when the facility is under the same management or ownership. 1. Evidence of a negative . . . . . examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual . . . . . examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . . . . . . 2. If any staff member has, or is suspected of having, a communicable . . . . . , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility . . . . . to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility	A 078		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968847	A. BUILDING: _____ B. WING _____	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIBBON CARE ASSISTED LIVING FACILITY, LL	125 AINSWORH CIR PALM SPRINGS, FL 33461

(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 078	Continued From page 11 and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff . . . . . by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure all staff have a one-time statement signed by a Health Care Provider attesting to freedom from communicable . . . . . in addition to annual documentation of freedom from . . . . . ( ) for 3 of 3 sampled staff (Administrator, Staff A and Staff B). The findings included: Review of the personnel file for the Administrator revealed a date of hire of . . . . . to work Monday through Friday from 11:00 AM to 5:00 PM and from 6:00 AM to 6:00 AM Saturday and Sunday. Further review of the personnel file revealed the one-time statement of freedom from communicable . . . and was dated . . . . There was no annual examination statement for 2022 or 2023. Review of the personnel file for Caregiver Staff A revealed a date of hire of . . . . . to work Monday through Friday from 6:00 AM to 6:00 AM (live in). Further review of the personnel file revealed no evidence of a one-time statement of	A 078		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968847	A. BUILDING: _____ B. WING _____	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIBBON CARE ASSISTED LIVING FACILITY, LL	125 AINSWORH CIR PALM SPRINGS, FL 33461

(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 078	Continued From page 12 freedom from communicable [illegible] including from a Health Care Provider. Review of the personnel file for Caregiver Staff B revealed a date of hire of [illegible] to work Monday through Friday from 6:00 AM to 6:00 PM. Further review of the personnel file revealed no evidence of a one-time statement of freedom from communicable [illegible] including [illegible] from a Health Care Provider. During an interview conducted with the Administrator on [illegible] at 3:30 PM, she acknowledged the findings. Class III	A 078		
A 082	59A-36.011(4) FAC Training - [illegible] / (4) [illegible] (/). Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on and [illegible], including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain evidence that staff completed the required one-hour training on [illegible] (/) within 30-days	A 082		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968847	A. BUILDING: _____ B. WING _____	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIBBON CARE ASSISTED LIVING FACILITY, LL	125 AINSWORH CIR PALM SPRINGS, FL 33461

(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 082	Continued From page 13 of hire for 1 of 3 sampled staff, Staff A. The findings included: Review of Caregiver Staff A's personnel file revealed a date of hire of to work Monday through Friday from 6:00 AM to 6:00 AM (live in). Further review of the personnel file revealed no evidence of the required / training. During an interview conducted with the Administrator on at 3:30 PM, the Administrator confirmed that the employee personnel files were missing some items. Class III	A 082		
A 083	59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND ( ). 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 that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency	A 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968847	A. BUILDING: _____ B. WING _____	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIBBON CARE ASSISTED LIVING FACILITY, LL	125 AINSWORH CIR PALM SPRINGS, FL 33461

(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 083	Continued From page 14 medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 3 of 3 sampled staff had the mandatory First Aid training, (Administrator, Staff A, and Staff B). The findings included: Review of the personnel file for the Administrator revealed a date of hire of . . . . . to work 11:00 AM to 5:00 PM Monday through Friday and 6:00 AM to 6:00 AM on Saturday and Sundays. Further review of the personnel file revealed the Administrator had no First Aid certification training documentation in the personnel file. Review of the personnel file for Caregiver Staff A revealed a date of hire of . . . . . to work 6:00 AM to 6:00 AM (live in) Monday through Friday. Further review of the personnel file revealed Caregiver Staff A had no First Aid certification training documentation in the personnel file. Review of the personnel file for Caregiver Staff B revealed a date of hire of to work 6:00 AM to 6:00 PM Monday through Friday. Further review of the personnel file revealed Caregiver Staff B had no First Aid certification training documentation in the personnel file. During an interview conducted with the Administrator on . . . . . at 3:30 PM, she acknowledged the findings. Class III	A 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968847	A. BUILDING: _____ B. WING _____	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIBBON CARE ASSISTED LIVING FACILITY, LL	125 AINSWORH CIR PALM SPRINGS, FL 33461

(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 093	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and	A 093		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968847	A. BUILDING: _____ B. WING _____	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIBBON CARE ASSISTED LIVING FACILITY, LL	125 AINSWORH CIR PALM SPRINGS, FL 33461

(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 093	Continued From page 16	A 093		

date reviewed. Portion sizes must be indicated on the menus or on a separate sheet.
1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences.
2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents.
(d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months.
(e) Therapeutic diets must be prepared and served as ordered by the health care provider.
1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility.
2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal.
(f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968847	A. BUILDING: _____ B. WING _____	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIBBON CARE ASSISTED LIVING FACILITY, LL	125 AINSWORH CIR PALM SPRINGS, FL 33461

(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 093	Continued From page 17 distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of . . . . . the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on . . . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, it was determined that the emergency 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, was not available during the survey. This could potentially affect the needs of 4 out of the 4 residents (Resident#1, Resident#2, Resident#3 and Resident #4) currently residing in the facility. The findings included: On at 3:10 PM, a review of the 3-day	A 093		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968847	A. BUILDING: _____ B. WING _____	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIBBON CARE ASSISTED LIVING FACILITY, LL	125 AINSWORH CIR PALM SPRINGS, FL 33461

(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 093	Continued From page 18	A 093		

emergency food supplies was conducted with the Administrator. The emergency foods were observed to be stored in the lower kitchen cabinets. The Administrator informed that she had to get more supplies due to some canned goods being out dated. This Surveyor reviewed and confirmed that some canned goods were outdated, and some cans were bent and rusted.

Review of the "Disaster Food Supplies List" prepared by the facility's [redacted] Dietitian, documented the required portions for a 3-day emergency food supply. This document was drafted for 6 people. There were four residents residing in the facility during this survey period.

Considering the current number of residents, it was noted that the required items for a 3-day emergency food supply was not available as indicated below:

Food item	Per Person/Per Day	Total Required	Available
Assorted fruit Juices	8	192 oz	0
Assorted Dry Cereals	1	24 oz	0
Milk Dry (Dry, boxed, evaporated)	16	384 oz	48 oz
Chicken Noodle Soup	2.66	64 oz	0
Cream of Mushroom soup	2.66	64 oz	0
Assorted canned Meat Pasta	2.66	64 oz	0
Chili With Beef	2.66	64 oz	0
Beef Stew or Chicken/Dumplings	2.66	64 oz	0
Jelly	1	24	

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
	AL11968847	A. BUILDING: _____ B. WING _____	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIBBON CARE ASSISTED LIVING FACILITY, LL	125 AINSWORH CIR PALM SPRINGS, FL 33461

(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 093	Continued From page 19 oz 0 Mixed Vegetables 4 96 oz 0 Graham Crackers or cookies 3 72 oz 0 Crackers 12 288 oz 0 The list was prepared and signed by the Facility's Dietitian. During an interview conducted with the Administrator on . . . . . at 3:10 PM, she acknowledged the findings and stated she will obtain the missing supplies by the next day. Class III	A 093		