

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/06/2023
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ASSISTED LIVING FACILITY

**2250 S SEMORAN BLVD
ORLANDO, FL 32822**

(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
CZ821	59A-35.110() FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal.	CZ821		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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CZ821	Continued From page 1 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , which is hereby incorporated by reference and available	CZ821	

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CZ821	Continued From page 2 at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780 , and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal . 5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123 , and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal . 6. For the purposes of this rule, the following applies for submitting adverse incident reports: a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up	CZ821			

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CZ821	Continued From page 3 to \$50 per day late not to exceed \$500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to electronically submit to the regulatory agency, a preliminary report within 1 business day and a full report within 15 days for 1 of 5 sampled residents who was at risk of harm or injury after eloping from the facility's secured memory care (#7). Findings: During an interview on _____ at 10:10 am, the administrator said the facility did not submit any preliminary and 15-day reports to the regulatory agency since _____. A review of resident #7's record revealed a facility admission date of _____. A _____ 1823 documented the resident's medical history including _____ with forgetfulness due to _____ and difficulties communicating needs. _____ 1823 documented the resident was at risk for elopement. During an interview on _____ at 10:20 am, staff A said that sometime earlier this year she watched a male resident (#7), she could not recall his last name, jump over the memory care fence.	CZ821		

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CZ821	Continued From page 4 Staff A said the resident was an exit seeker and would say he did not belong here and wanted to go home. Staff A said that when she saw the resident on the fence, she told him to get down. He began cursing at her. She did not know if he would become aggressive towards her if she tried to assist him down, so rather than try, she called for staff assistance over the radio. Staff A said that after the resident jumped the fence, he squeezed through the closed gate at the entrance of the facility then crossed over the six-lane road that ran in front of the facility. Staff A said she drove in her car and watched the resident walk. She said other staff were on but were unable to catch up to him. She said the resident ended up near a bank located approximately one-half mile from the facility. She said the administrator responded and was able to calm the resident down until his family member arrived and took the resident home with them. Staff A said she could not remember if she received training on the facility's elopement policy. She said following the resident's elopement the administrator held a monthly staff meeting and emphasized elopement procedures. The facility's resident elopement policy and procedure defined resident elopement as that situation where a resident leaves the facility grounds without the staff's knowledge and fails to follow the facility policy for signing in and out and the resident was at risk for injury or sustained an injury. A review of a 5:48 pm note authored by the administrator documented, in part, that the resident's 1823 documented the resident was an elopement risk and had difficulty communicating. As a precaution and until the resident was seen by a psychiatrist and a primary practitioner to	CZ821			

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CZ821	Continued From page 5 determine appropriateness to live in assisted living, he was moved to the facility's secured memory care unit. A review of a 4:49 pm note authored by the prior director of nursing (DON) documented, in part, care staff reported the resident was exit-seeking during the day. The resident also said, "I will put this table by the fence and jump this fence". The DON witnessed the resident push on the emergency egress doors that were secured and locked. The resident's family was called by the administrator and the prior DON, who strongly recommended the family hire a private sitter. The administrator and the prior DON implemented facility staff one-on-one until the family provided their own. A review of a 4:38 pm note authored by the administrator documented, in part, staff reported the resident was still and exit-seeking. Facility staff continued one-on-one for safety and due to the resident's continued comments of hopping the fence. The resident was seen by a psychiatrist, who recommended the resident remain in memory care. A review of a 9:45 pm note authored by the administrator documented, in part, the administrator received a call at approximately 7:30 pm that the resident had become aggressive with staff and went outside into the enclosed courtyard continuing to be verbally threatening while he walked around and climbed the fence. One-on-one care staff followed behind at all times. The receptionist had the resident on camera while he was in the parking lot. Staff attempted redirection with the resident yelling and threatening them. Staff closed the gate to the community and the resident climbed under it to	CZ821	

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CZ821	Continued From page 6 leave the property. Staff followed the resident down the road in front of the facility where he stopped at a bus stop. The resident was on the phone with his family member the entire time. The family member said there was a tracker on the resident. The administrator arrived at the bus stop. The resident was upset with the family member for not coming to take him to the hospital to see his girlfriend. The resident said that was where he was going and that he signed the paper like he was supposed to. The family member arrived at the bus stop and returned the resident to the facility in their car. The resident was immediately discharged from the facility and went home with the family member. During an interview on at 12:50 pm, the administrator said that when a resident is identified as an elopement risk upon admission, they are either admitted to the secured memory care or are required to have 24-hour private sitter for five days. She said resident #7 kept leaving his last facility without signing in and out so that facility transferred him to their independent living then ultimately discharged him to this facility. She said that when the resident was admitted she was on vacation. She said neither the prior DON nor the prior marketing employee communicated with her before moving the resident in. She then said that despite telling them both the resident had to live in memory care, the prior DON made the decision on her own to place the resident in an unsecured assisted living apartment. She said that when she returned from vacation, she decided to move him to the secured memory care until it could be determined if he was truly an elopement risk. She said she did not submit a preliminary and 15-day report to the regulatory agency because the resident did not meet the facility's definition of elopement. She did not	CZ821			

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CZ821	Continued From page 7 believe the resident was at risk for harm when he eloped because he was able to get on a bus at his last facility. She then said, "I felt like he was safe because they were with him", referring to facility staff. She said the resident was not able to make his own decision to leave. During an interview on _____ at 3 pm, staff A said that ever since resident #7 moved to memory care he was exit seeking. She said the resident oftentimes opened the doors which set off a screamer alarm. Staff A said that after dinner on _____ the resident started telling staff that someone was in the hospital, and he had to get out of here. Staff A said she heard the courtyard door alarm sound. She responded to the alarm and saw the resident in the courtyard and on his phone. Staff A said she followed behind the resident then saw him climbing the fence. She told the resident to get down. She was afraid the resident would hit her. The resident started cursing at her, called her names and told her not to come near him. She told him that if he did not get down, she would call the police and the resident replied, "go ahead". Staff A radioed the front desk receptionist, told the receptionist the resident jumped the fence then asked if the receptionist had _____ on the resident. Staff A then paged all staff who were able to come down and informed them the resident jumped the fence. Staff A then told caregiver C she was leaving memory care. Staff A went to the parking lot, saw the resident there and asked him to stop. The resident was walking towards the front gate. Another staff member, she could not recall who, closed the electronic gate and staff A told the resident she was going to call his family member. The resident then squeezed through where the two gate doors meet. The resident then turned around and said expletives towards the staff who	CZ821			

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CZ821	Continued From page 8 were present. Staff A ran to her car and began following the resident. Staff A saw him turn left in front of a fast-food restaurant in front of the facility then proceed to walk in the direction of a parking lot of a shopping center located approximately one-quarter mile from the facility. Staff A said because she was in her car on the opposite side from where the resident was walking, she could only see the top of his head while he was walking in the parking lot. Staff A said that after passing the bank mentioned earlier, the resident used the cross walk to cross a four-lane road then walked between cars to cross the six-lane road to a bus stop. Staff A said she parked at the fast-food restaurant next to the bus stop and was not comfortable with approaching the resident. She said the administrator and the resident's family member later arrived and took over. Staff A said none of the other staff followed the resident on because she was going in her car. Staff A said the resident did not have one-on-one staff assigned to him when he eloped. The courtyard fence the resident climbed was the fence door. When asked why she did not unlock the door and follow the resident rather than going through the facility staff A replied, "because I was afraid, he was gonna hit me". A request was made of the administrator on 12/06/2023 at 3:45 pm to view the camera footage. The administrator replied that the footage was saved for only thirty days. During an interview on 12/06/2023 at 4:23 pm, the administrator said she first learned about the tracker on the resident when the resident's family member told her on the day the resident eloped. During an interview on 12/06/2023 at 12:34 pm, the	CZ821		

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CZ821	Continued From page 9 receptionist who staff A alerted of the elopement said "I was at the front desk, and they radioed me that he hopped the gate, so I watched for him through the front doors. When he got in my line of site I went outside. I talked to him for a second and tried to dissuade him from leaving. He had his mind set that he did not want to be where he was. I just walked with him until nursing staff came out. I saw him push through the outside gate. I went inside after (staff A) began to follow him. When he lived on the assisted living side he came down and would sign himself out and come He would ask me where stuff was around like (a nearby grocery store) and all that stuff". During an interview on at 12:42 pm, the prior DON said regarding resident #7, "he was a really sweet guy. There were no behaviors until the ED (executive director) made the decision to move him to memory care due to the diagnoses on his 1823. He would sign out due to visitors taking him out while he lived in assisted living. When I got there (referring to her responding to the facility when he eloped) the ED had already gotten him to the building". The DON went on to say that she viewed the camera footage of that day and saw the resident moved a table to the fence, climbed on it then jumped the fence. The DON said the footage showed a time when staff A was not behind him. The DON said that following the elopement, no modifications were considered or made to either the memory care fence or the one in the front where the resident squeezed through, no furniture was removed from the courtyard and no training was offered to the staff. During an interview on at 1 pm, resident #7's family member said that immediately prior to	CZ821	

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CZ821	Continued From page 10 the resident moving into this facility he lived at an assisted living facility where he was at some point moved to the independent living section. The family member said the resident was doing fine there and he would go out on his own but forget to sign out. The family member said the facility eventually discharged him for reasons she did not know. The family member said the resident moved into this facility and per staff reports the resident would remember to sign out most of the time. The family member was then told the resident was exit seeking, so he was moved to the secured memory care unit. The family member was then told the resident was exit seeking there also so they "kicked him out". The family member said they implemented the air tags because when the resident was at home he'd leave and forget where exactly he was. He'd go out for walks and forget where he was. The family member said the resident had a phone but was not good at using it. Review of the memory care sign-in and out log revealed the resident signed out on _____ at 7:30. Unclassified	CZ821			
A 000	Initial Comments Two Complaint Investigations (#2023009397 and #2023012994) were conducted at Assisted Living Facility on _____. The facility had deficiencies at the time of the survey.	A 000			
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26	A 025			

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A 025	Continued From page 11 (7) The facility shall notify a licensed physician when a resident exhibits signs of _____ or _____ or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such _____ or _____. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making _____ for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider	A 025	

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A 025	Continued From page 12 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 record reviews and interviews, the facility failed to provide adequate supervision when 1 of 5 sampled residents eloped from the secured memory care unit (#7). Findings: A review of resident #7's record revealed a facility admission date of A 1823 documented the resident's medical history including with forgetfulness due to and difficulties communicating needs. 1823 documented the resident was at risk for elopement. During an interview on at 10:20 am, staff A said that sometime earlier this year she watched a male resident (#7), she could not recall his last name, jump over the memory care fence. Staff A said the resident was an exit seeker and would say he did not belong here and wanted to go home. Staff A said that when she saw the resident on the fence, she told him to get down. He began cursing at her. She did not know if he	A 025		

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NAME OF PROVIDER OR SUPPLIER ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2250 S SEMORAN BLVD ORLANDO, FL 32822		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 025	Continued From page 13 would become aggressive towards her if she tried to assist him down, so rather than try, she called for staff assistance over the radio. Staff A said that after the resident jumped the fence, he squeezed through the closed gate at the entrance of the facility then crossed over the six-lane road that ran in front of the facility. Staff A said she drove in her car and watched the resident walk. She said other staff were on ... but were unable to catch up to him. She said the resident ended up near a bank located approximately one-half mile from the facility. She said the administrator responded and was able to calm the resident down until his family member arrived and took the resident home with them. Staff A said she could not remember if she received training on the facility's elopement policy. She said following the resident's elopement the administrator held a monthly staff meeting and emphasized elopement procedures. The facility's resident elopement policy and procedure defined resident elopement as that situation where a resident leaves the facility grounds without the staff's knowledge and fails to follow the facility policy for signing in and out and the resident was at risk for injury or sustained an injury. A review of a 5:48 pm note authored by the administrator documented, in part, that the resident's 1823 documented the resident was an elopement risk and had difficulty communicating. As a precaution and until the resident was seen by a psychiatrist and a primary practitioner to determine appropriateness to live in assisted living, he was moved to the facility's secured memory care unit. A review of a 4:49 pm note authored by	A 025			

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A 025	Continued From page 14 the prior director of nursing (DON) documented, in part, care staff reported the resident was exit-seeking during the day. The resident also said, "I will put this table by the fence and jump this fence". The DON witnessed the resident push on the emergency egress doors that were secured and locked. The resident's family was called by the administrator and the prior DON, who strongly recommended the family hire a private sitter. The administrator and the prior DON implemented facility staff one-on-one until the family provided their own. A review of a 4:38 pm note authored by the administrator documented, in part, staff reported the resident was still and exit-seeking. Facility staff continued one-on-one for safety and due to the resident's continued comments of hopping the fence. The resident was seen by a psychiatrist, who recommended the resident remain in memory care. A review of a 9:45 pm note authored by the administrator documented, in part, the administrator received a call at approximately 7:30 pm that the resident had become aggressive with staff and went outside into the enclosed courtyard continuing to be verbally threatening while he walked around and climbed the fence. One-on-one care staff followed behind at all times. The receptionist had the resident on camera while he was in the parking lot. Staff attempted redirection with the resident yelling and threatening them. Staff closed the gate to the community and the resident climbed under it to leave the property. Staff followed the resident down the road in front of the facility where he stopped at a bus stop. The resident was on the phone with his family member the entire time. The family member said there was a tracker on	A 025			

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ASSISTED LIVING FACILITY

**2250 S SEMORAN BLVD
ORLANDO, FL 32822**

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A 025	Continued From page 15 the resident. The administrator arrived at the bus stop. The resident was upset with the family member for not coming to take him to the hospital to see his girlfriend. The resident said that was where he was going and that he signed the paper like he was supposed to. The family member arrived at the bus stop and returned the resident to the facility in their car. The resident was immediately discharged from the facility and went home with the family member. During an interview on _____ at 12:50 pm, the administrator said that when a resident is identified as an elopement risk upon admission, they are either admitted to the secured memory care or are required to have 24-hour private sitter for five days. She said resident #7 kept leaving his last facility without signing in and out so that facility transferred him to their independent living then ultimately discharged him to this facility. She said that when the resident was admitted she was on vacation. She said neither the prior DON nor the prior marketing employee communicated with her before moving the resident in. She then said that despite telling them both the resident had to live in memory care, the prior DON made the decision on her own to place the resident in an unsecured assisted living apartment. She said that when she returned from vacation, she decided to move him to the secured memory care until it could be determined if he was truly an elopement risk. She did not believe the resident was at risk of harm when he eloped because he was able to get on a bus at his last facility. She then said, "I felt like he was safe because they were with him", referring to facility staff. She said the resident was not able to make his own decision to leave. During an interview on _____ at 3 pm, staff A	A 025		

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A 025	Continued From page 16 said that ever since resident #7 moved to memory care he was exit seeking. She said the resident oftentimes opened the doors which set off a screamer alarm. Staff A said that after dinner on _____ the resident started telling staff that someone was in the hospital, and he had to get out of here. Staff A said she heard the courtyard door alarm sound. She responded to the alarm and saw the resident in the courtyard and on his phone. Staff A said she followed behind the resident then saw him climbing the fence. She told the resident to get down. She was afraid the resident would hit her. The resident started cursing at her, called her names and told her not to come near him. She told him that if he did not get down, she would call the police and the resident replied, "go ahead". Staff A radioed the front desk receptionist, told the receptionist the resident jumped the fence then asked if the receptionist had _____ on the resident. Staff A then paged all staff who were able to come down and informed them the resident jumped the fence. Staff A then told caregiver C she was leaving memory care. Staff A went to the parking lot, saw the resident there and asked him to stop. The resident was walking towards the front gate. Another staff member, she could not recall who, closed the electronic gate and staff A told the resident she was going to call his family member. The resident then squeezed through where the two gate doors meet. The resident then turned around and said expletives towards the staff who were present. Staff A ran to her car and began following the resident. Staff A saw him turn left in front of a fast-food restaurant in front of the facility then proceed to walk in the direction of a parking lot of a shopping center located approximately one-quarter mile from the facility. Staff A said because she was in her car on the opposite side from where the resident was	A 025			

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A 025	Continued From page 17 walking, she could only see the top of his while he was walking in the parking lot. Staff A said that after passing the bank mentioned earlier, the resident used the cross walk to cross a four-lane road then walked between cars to cross the six-lane road to a bus stop. Staff A said she parked at the fast-food restaurant next to the bus stop and was not comfortable with approaching the resident. She said the administrator and the resident's family member later arrived and took over. Staff A said none of the other staff followed the resident on because she was going in her car. Staff A said the resident did not have one-on-one staff assigned to him when he eloped. The courtyard fence the resident climbed was the fence door. When asked why she did not unlock the door and follow the resident rather than going through the facility staff A replied, "because I was afraid, he was gonna hit me". A request was made of the administrator on at 3:45 pm to view the camera footage. The administrator replied that the footage was saved for only thirty days. During an interview on at 4:23 pm, the administrator said she first learned about the tracker on the resident when the resident's family member told her on the day the resident eloped. During an interview on at 12:34 pm, the receptionist who staff A alerted of the elopement said "I was at the front desk, and they radioed me that he hopped the gate, so I watched for him through the front doors. When he got in my line of site I went outside. I talked to him for a second and tried to dissuade him from leaving. He had his mind set that he did not want to be where he was. I just walked with him until nursing staff	A 025	

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A 025	Continued From page 18 came out. I saw him push through the outside gate. I went inside after (staff A) began to follow him. When he lived on the assisted living side he came down and would sign himself out and come He would ask me where stuff was around like (a nearby grocery store) and all that stuff". During an interview on at 12:42 pm, the prior DON said regarding resident #7, "he was a really sweet guy. There were no behaviors until the ED (executive director) made the decision to move him to memory care due to the diagnoses on his 1823. He would sign out due to visitors taking him out while he lived in assisted living. When I got there (referring to her responding to the facility when he eloped) the ED had already gotten him to the building". The DON went on to say that she viewed the camera footage of that day and saw the resident move a table to the fence, climbed on it then jumped the fence. The DON said the footage showed a time when staff A was not behind him. The DON said that following the elopement, no modifications were considered or made to either the memory care fence or the one in the front where the resident squeezed through, no furniture was removed from the courtyard and no training was offered to the staff. During an interview on at 1 pm, resident #7's family member said that immediately prior to the resident moving into this facility he lived at an assisted living facility where he was at some point moved to the independent living section. The family member said the resident was doing fine there and he would go out on his own but forget to sign out. The family member said the facility eventually discharged him for reasons she did not know. The family member said the resident	A 025			

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A 025	Continued From page 19 moved into this facility and per staff reports the resident would remember to sign out most of the time. The family member was then told the resident was exit seeking, so he was moved to the secured memory care unit. The family member was then told the resident was exit seeking there also so they "kicked him out". The family member said they implemented the air tags because when the resident was at home he'd leave and forget where exactly he was. He'd go out for walks and forget where he was. The family member said the resident had a phone but was not good at using it. Review of the memory care sign-in and out log revealed the resident signed out on _____ at 7:30. Class II	A 025			
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2) (a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or	A 032			

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A 032	Continued From page 20 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the	A 032			

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A 032	Continued From page 21 facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure its resident elopement policy contained the required information and failed to ensure and have documentation to indicate 2 of 4 sampled staff participated in a minimum of two resident elopement drills each year (C and D). Findings: Review of the facility's resident elopement policy revealed it did not contain the provision that facility staff would make, at a minimum, a daily effort to ensure residents identified as being at risk for elopement had identification on their person that included their name, the facility's name, address, and telephone number. A record review of Staff C revealed a hire date of _____. A record review of Staff D revealed a hire date on _____. On _____, the facility's elopement drill rosters for _____ and _____. Did not list Staff C and Staff D attended any of the drills held. On _____ at 5 pm, the administrator confirmed the findings.	A 032		

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A 032	Continued From page 22 Class III	A 032		
A 052 SS=D	429.256(. . .); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an . . . syringe that is prefilled with the proper dosage by a pharmacist and an . . . that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her (d) Applying . . . medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section.	A 052		

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A 052	Continued From page 23 (g) Assisting with the use of a _____, including removing the cap of a _____, opening the unit dose of _____ solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the _____. (4) Assistance with self-administration of medication does not include: (a) Mixing, _____, converting, or _____ medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a _____ of the body. (d) Administration of _____ preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with _____, or _____ preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered	A 052		

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A 052	Continued From page 24 administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be _____ or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a	A 052			

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A 052	Continued From page 25 medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observations, review and interview, the facility failed to ensure the unlicensed staff who assisted 2 of 2 sampled residents with medications followed the correct procedures (#9 and #10). Findings: Observations made during a medication pass for resident #9 on at 11:05 am revealed the resident sat approximately 8' from the cart.	A 052			

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A 052	Continued From page 26 Med tech B popped the pills while standing at the cart and not in the resident's presence. When she took the pills to the resident, she did not say the name and dosage of each medication aloud. The resident's record did not contain a waiver to exempt the med tech from the requirement. Observations made during a medication pass for resident #10 on at 11:09 am revealed med tech B again prepared the resident's medications at the cart and did not say the name and dosage of each medication aloud. This resident too did not have a waiver. Following the med passes, med tech B confirmed her errors and said she was trained on providing assistance with self-administered medications. The med tech then said, "I'm just a little nervous right now". Class III	A 052	
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be	A 054	

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NAME OF PROVIDER OR SUPPLIER ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2250 S SEMORAN BLVD ORLANDO, FL 32822		
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A 054	Continued From page 27 immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure the Medication Observation Record (MOR) for 1 of 5 sampled residents was properly updated (#9). Findings: A review of resident #9's health assessment form (1823) revealed the resident required assistance with self-administration of medications. A review of the resident's MOR revealed "resident unavailable" was documented on and . Neither the MOR nor the resident's record contained documentation further explaining the resident's unavailability and/or whether the resident received the medications. On at 1:30 pm, the findings were	A 054			

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A 054	Continued From page 28 discussed with the resident care director (RCD) with an opportunity given to provide additional documentation. On at 4:30 pm, the administrator was told what documentation was not received from the RCD. Neither the RCD nor the administrator provided additional documentation or further explanation. Class III	A 054			
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-26.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the	A 056			

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A 056	Continued From page 29 circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for, , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be	A 056			

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A 056	Continued From page 30 kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure medications were refilled in a timely manner to ensure doses were not missed for 1 of 5 sampled residents who required assistance with self-administration of medications (#9). Findings: A review of resident #9's health assessment form (1823) revealed the resident's medical history included _____ and _____, and the resident required assistance with self-administration of medications. Review of the resident's _____ MOR	A 056			

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ASSISTED LIVING FACILITY

**2250 S SEMORAN BLVD
ORLANDO, FL 32822**

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A 056	Continued From page 31 revealed _____ was "not available-pending refill-md/family/pharmacy notified: meds no" was documented on _____ and _____ Review of the resident's _____ MOR revealed _____ was "not available-pending refill-md/family/pharmacy notified: meds no" was documented from _____ through _____ Neither the MORs nor the resident's record contained documented details of who the practitioner was that was notified and any follow-up communication. On _____ at 1:30 pm, the RCD said regarding only the _____ that the psychiatrist who prescribed it no longer came to the facility and there was a lapse until the new practitioner started. She said the resident's primary care practitioner said have a psych doctor refill the medication. The RCD did not offer an explanation for the _____ Class III	A 056		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011() FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility	A 081		

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A 081	Continued From page 32 must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff:	A 081	

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A 081	Continued From page 33 (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in _____ control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its _____ control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to _____ borne _____, may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident _____, neglect, and _____. The facility must use its _____ prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs.	A 081			

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A 081	Continued From page 34 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to obtain the staff in-service training for 1 of 4 sampled staff (C) within 30 days of employment as required. Findings: Staff C's record review revealed a hire date of . A 2-hour certificate for pre-service orientation and all other required in-service training dated . There was no evidence of documented in-service trainings for: a. 1hr - Resident Rights and Recognizing/Reporting /Neglect Training. On at 5:30pm The Administrator	A 081			

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A 081	Continued From page 35 confirmed the findings and provided no additional documentation. Class III	A 081		
A 084 SS=D	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfillment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for _____ control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance.	A 084		

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A 084	Continued From page 36 (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, _____ dosage forms, and _____ and _____ dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with _____ syringes that are prefilled with the proper dosage by a pharmacist and _____ that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection; i. Assist with _____; j. Use a _____ to perform _____ testing; k. Assist residents with _____ and continuous positive airway pressure (CPAP)	A 084		

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A 084	Continued From page 37 devices, excluding the titration of the _____ levels; l. Apply and remove _____ stockings and hosiery; m. Placement and removal of _____ bags, excluding the removal of the _____ or manipulation of the _____ site; and, n. Measurement of _____ rate, temperature, and _____ rate. (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by	A 084			

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A 084	Continued From page 38 rule the minimum requirements of this training This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 3 of 3 sampled unlicensed staff who assisted with medications received the required training in person and not only online (A, B, C). Findings: 1. A review of staff A's personnel record revealed a hire date of . The record contained an . certified nursing assistant/med technician job description and a activity assistant job description. A review of an . 6-hour medication technician training certificate revealed it was obtained through online learning and not in person, as required. On at 10:20 am, staff A said that she works primarily as the activity assistant, but she assists residents with medications when the facility needs her to. 2. Observations made on . at 11:05 am and 11:09 am revealed med tech B gave medications to residents #9 and #10. A review of a 6-hour medication technician training certificate revealed it was obtained through online learning and not in person, as required. On at 4:23 pm, the administrator confirmed the findings and said she thought it was still acceptable to take the training online. 3. On a review of Staff C's record revealed a Certificate of Completion 6 hour	A 084		

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A 084	Continued From page 39 Medication Technician issued on _____ On _____ at 5:30pm The Administrator confirmed Staff C's medication training certificate was from an on line course which was approved during COVID. Class III	A 084			
A 086 SS=D	59A-36.011(10) FAC Training - ADRD (10) AND RELATED ("ADRD") TRAINING REQUIREMENTS. Facilities which advertise that they provide special care for persons with ADRD, or who maintain secured areas as described in Chapter 4, Section 464.4.6 of the Florida Building Code, as adopted in rule 61G20-1.001, F.A.C., Florida Building Code Adopted, must ensure that facility staff receive the following training. (a) Facility staff who interact on a daily basis with residents with ADRD but do not provide direct care to such residents and staff who provide direct care to residents with ADRD, shall obtain 4 hours of initial training within 3 months of employment. Completion of the core training program between _____ and _____ shall satisfy this requirement. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. Initial training, entitled " _____ and Related _____ Level I Training," must address the following subject areas: 1. Understanding _____'s _____ and related _____ 2. Characteristics of _____; 3. Communicating with residents with _____;	A 086			

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NAME OF PROVIDER OR SUPPLIER ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2250 S SEMORAN BLVD ORLANDO, FL 32822		
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A 086	Continued From page 40 4. Family issues; 5. Resident environment; and, 6. Ethical issues. (b) Staff who have successfully completed both the initial one hour and continuing three hours of ADRD training pursuant to sections 400.1755, 429.917 and 400.6045(1), F.S., shall be considered to have met the initial assisted living facility _____ and Related _____ Level I Training. (c) Facility staff who provide direct care to residents with ADRD must obtain an additional 4 hours of training, entitled " _____ and Related _____ Level II Training," within 9 months of employment. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. _____ and Related _____ Level II Training must address the following subject areas as they apply to these _____: 1. Behavior management, 2. Assistance with ADLs, 3. Activities for residents, 4. Stress management for the care giver; and, 5. Medical information. (d) A detailed description of the subject areas that must be included in an ADRD curriculum which meets the requirements of paragraphs (a) and (b) of this subsection, can be found in the document "Training Guidelines for the Special Care of Persons with _____'s _____ and Related _____," dated _____, incorporated by reference, available from the Department of Elder Affairs, 4040 Esplanade Way, Tallahassee, Florida 32399-7000. (e) Direct care staff shall participate in 4 hours of continuing education annually as required under section 429.178, F.S. Continuing education	A 086			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/06/2023
NAME OF PROVIDER OR SUPPLIER ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2250 S SEMORAN BLVD ORLANDO, FL 32822		
(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 086	Continued From page 41 received under this paragraph may be used to meet 3 of the 12 hours of continuing education required by section 429.52, F.S., and subsection (1) of this rule, or 3 of the 6 hours of continuing education for extended congregate care required by subsection (7) of this rule. (f) Facility staff who have only incidental contact with residents with ADRD must receive general written information provided by the facility on interacting with such residents, as required under section 429.178, F.S., within three (3) months of employment. "Incidental contact" means all staff who neither provide direct care nor are in regular contact with such residents. (g) Persons who seek to provide ADRD training in accordance with this subsection must provide the department or its designee with documentation that they hold a Bachelor's degree from an accredited college or university or hold a license as a registered nurse, and: 1. Have 1 year teaching experience as an educator of caregivers for persons with _____, or related _____, or 2. Three years of practical experience in a program providing care to persons with _____, or related _____, or 3. Completed a specialized training program in the subject matter of this program and have a minimum of two years of practical experience in a program providing care to persons with _____, or related _____. (h) With reference to requirements in paragraph (g), a Master's degree from an accredited college or university in a subject related to the content of this training program can substitute for the teaching experience. Years of teaching experience related to the subject matter of this training program may substitute on a year-by-year basis for the required Bachelor's degree	A 086			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/06/2023
NAME OF PROVIDER OR SUPPLIER ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2250 S SEMORAN BLVD ORLANDO, FL 32822		
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A 086	Continued From page 42 referenced in paragraph (g). This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to ensure that 1 of 4 sampled staff (C) completed 4 hours, Level I and Related (ADRD) training within 3 months with an additional 4 hours, Level II within 9 months of employment as required. Findings: Staff C's record review revealed a hire date . There was no documented evidence that Level I, 4 hours within 3 months and Level II within 9 months ADRD training was completed. On at 5:30pm The Administrator confirmed the findings. Class III	A 086			