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
	AL11911313	A. BUILDING: _____ B. WING _____	12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALABAMA OAKS OF WINTER PARK	1759 ALABAMA DRIVE WINTER PARK, FL 32789

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A re-licensure survey and a generator monitoring was conducted at Alabama Oaks of Winter Park on . The facility had deficiencies at the time of the survey.	A 000		
A 010 SS=D	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, and the resident is under the care of a physician	A 010		

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A 010	Continued From page 1 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		

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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 [illegible]-to-[illegible] 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 [illegible], [illegible] 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, 3. If the resident's condition fails to improve within	A 010		

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A 010	Continued From page 3 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 described in Rule 59A-36.021, F.A.C.	A 010		

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A 010	Continued From page 4 This Statute or Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure 1 of 2 sampled residents had a coordinated plan of care (POC) which delineated how the facility and the hospice would meet the scheduled and unscheduled needs of the resident (#7). Findings: A review of resident #7's record revealed a facility admission date of . A review of a hospice document revealed the resident was on hospice services. A review of the resident's record revealed it did not contain a coordinated POC which delineated how the facility and the hospice would meet the scheduled and unscheduled needs of the resident. On at 4:50 pm, the administrator confirmed the finding and was unable to provide additional documentation. Class III	A 010		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification	A 025		

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A 025	Continued From page 5 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 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	A 025		

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A 025	Continued From page 6 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 2 sampled residents eloped from the facility (#3). Findings: A review of resident #3's record revealed a facility admission date of . . . . . The resident's medical history included mild ᵕ , with memory disturbance. A . . . . health assessment form (1823) documented the resident was unaware of his limitations and was at risk for elopement. The resident ambulated independently and was independent with bathing, ᵕ, grooming and toileting. A review of facility documentation in the resident's record revealed the following: On . . . . . the resident stripped naked in his room and said he was leaving to go home. On he left the facility around 8:30 pm and caregiver B found him near the facility's sister facility located approximately one mile from this facility. On at 2 pm a caregiver went to help another resident. One hour later a call was	A 025		

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A 025	Continued From page 7 received at the facility that the resident was at the hospital. One of the men who was doing yard work had not locked the gate and the resident left. The activities staff member picked the resident up from the hospital and returned him to the facility. On at approximately 1:30 pm the resident went outside to look for his family member. On and he was looking for his family member during the night. On he was and wanted to go to his house. On he was , looking for his family member and his house key. On the administrator documented that she received a call from facility staff at 6 am informing her the resident was not at the facility. Facility staff did a full property search before calling the administrator. The administrator called the resident's phone and a nurse at a local hospital answered the phone and said the resident was dropped off at their emergency room. A hospital history and physical documented the resident arrived at the emergency department at 6:06 am. Emergency medical services reported to the hospital that the resident was walking around knocking on doors asking people where he was. Those homeowners then called the fire department due to the resident's to get him home. Per the fire department the resident was very upon arrival at the scene, so they brought the resident	A 025		

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A 025	Continued From page 8 to the hospital to be evaluated. The facility's undated resident elopement policy defined elopement as a resident has left the property and did not inform staff of where he or she was going, and eight hours has passed without anyone seeing the resident. Unless the resident has been defined by management as a high-risk resident, then it would be if no one has seen the resident in three hours. The policy defined a high-risk resident as one who has no ability to communicate where he or she lives. Or one who has been determined by their physician to need a higher level of monitoring. During an interview on at 9:32 am, resident #3 said he was walking around outside naked and did not know why. He said he was moving out of this facility. Despite asking follow up questions, the resident was unable to further. During an interview on at 3:15 pm, the administrator said regarding the elopement that she recalled the resident walked along the parameter of the left side of the property to a section that was not fenced, was found there by staff then returned to the facility. During an interview on at 4:35 pm, the activities staff who picked the resident up from the hospital on said she recalled only that a facility staff member called her as she was coming to start her 1 pm shift and instructed her to pick up the resident. During an interview on at 2:08 pm, caregiver C said regarding the	A 025		

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A 025	Continued From page 9 elopement that her co-worker alerted her that resident #3 could not be found in the facility. Caregiver C said both inside and outside of the facility was searched. Caregiver C said resident #3 called the administrator and described where he was. Caregiver C then got in her car and found the resident standing on a sidewalk near the facility. The caregiver believed the resident got out when someone delivered a prescription then left the gate open. The caregiver said as a result the gate code was changed. She said the resident oftentimes says there is someone after him and he wants to go home. She said she tries to talk with him when he's like that. She said measures taken by the facility to prevent further elopements included adding an additional piece of fence to completely close in the front of the property and the administrator instructed the staff to check on the resident often to see if he's in his room or on the premises. During an interview on at 2:26 pm, caregiver B said that when the resident is , he says he wants to leave. She believed when the resident eloped on that men working on the yard left the gate open. She said the administrator met with the staff and instructed them to keep an , on the resident and she also believed his medications were adjusted. During an interview on at 10 am, the administrator said steps taken by the facility to prevent resident #3 from further eloping was the gate code was changed, the section of the unfenced property was fenced in, and staff were instructed to check on the resident more frequently during the night shift. Class II	A 025		

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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 's ; 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.	A 086		

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A 086	Continued From page 11 (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 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	A 086		

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A 086	Continued From page 12 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 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 3 sampled staff completed 4 hours Related (ADRD) Level II training within 9 months of employment. Findings:	A 086		

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A 086	Continued From page 13 A review of the administrator's personnel record revealed a hire date of . The record did not contain documentation to indicate the administrator completed 4 hours of ADRD level II training within 9 months of employment. On at 5:07 pm, the administrator said she did complete the training but could not locate it in her personnel record. Class III	A 086		
A 093 SS=D	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	A 093		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALABAMA OAKS OF WINTER PARK	1759 ALABAMA DRIVE WINTER PARK, FL 32789

(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 14 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 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	A 093		

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A 093	Continued From page 15 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 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:	A 093		

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A 093	Continued From page 16 Based on observation, review of the facility's comprehensive emergency management plan (CEMP) and interview, the facility failed to have water sufficient for drinking and food preparation stored on or have a plan for obtaining water in an emergency. Findings: A review of the facility's resident census revealed a total of sixteen residents. Therefore, the facility was required to have eighty gallons of water sufficient for drinking and food preparation stored on or have a plan for obtaining water in an emergency. At the time of the visit the facility had a total of thirty-five gallons of water on . A review of the facility's CEMP, approved by emergency management on , revealed it did not contain a plan for obtaining additional water in an emergency. On at 2:35 pm, the administrator confirmed the findings. Class III	A 093		
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.,	CZ821		

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CZ821	Continued From page 17 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. 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	CZ821		

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CZ821	Continued From page 18 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 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.	CZ821		

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CZ821	Continued From page 19 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 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	CZ821		

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CZ821	Continued From page 20 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 2 sampled residents who was at risk of harm or injury after eloping from the facility (#3). Findings: On [redacted] at 10:05 am, the administrator said the facility did not have any incidents that required notification to the regulatory agency over the previous two years. A review of resident #3's record revealed a facility admission date of [redacted]. The resident's medical history included mild [redacted] with memory disturbance. A [redacted] health assessment form (1823) documented the resident was unaware of his limitations and was at risk for elopement. The resident ambulated independently and was independent with bathing, [redacted], grooming and toileting. A review of facility documentation in the resident's record revealed the following: On [redacted] the resident stripped naked in his room and said he was leaving to go home. On [redacted] he left the facility around 8:30 pm and caregiver B found him near the facility's sister facility located approximately one mile from this facility.	CZ821		

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CZ821	Continued From page 21 On [redacted] at 2 pm a caregiver went to help another resident. One hour later a call was received at the facility that the resident was at the hospital. One of the men who was doing yard work had not locked the gate and the resident left. The activities staff member picked the resident up from the hospital and returned him to the facility. On [redacted] at approximately 1:30 pm the resident went outside to look for his family member. On [redacted] and [redacted] he was looking for his family member during the night. On [redacted] he was [redacted] and wanted to go to his house. On [redacted] he was [redacted], looking for his family member and his house key. On [redacted] the administrator documented that she received a call from facility staff at 6 am informing her the resident was not at the facility. Facility staff did a full property search before calling the administrator. The administrator called the resident's phone and a nurse at a local hospital answered the phone and said the resident was dropped off at their emergency room. A [redacted] hospital after visit summary documented the resident was seen for [redacted]. The facility's undated resident elopement policy defined elopement as a resident has left the property and did not inform staff of where he or she was going, and eight hours has passed	CZ821		

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CZ821	Continued From page 22 without anyone seeing the resident. Unless the resident has been defined by management as a high-risk resident, then it would be if no one has seen the resident in three hours. The policy defined a high-risk resident as one who has no ability to communicate where he or she lives. Or one who has been determined by their physician to need a higher level of monitoring. During an interview on at 9:32 am, resident #3 said he was walking around outside naked and did not know why. He said he was moving out of this facility. Despite asking follow up questions, the resident was unable to further. During an interview on at 3:15 pm, the administrator said regarding the elopement that she recalled the resident walked along the parameter of the left side of the property to a section that was not fenced, was found there by staff then returned to the facility. During an interview on at 4:35 pm, the activities staff who picked the resident up from the hospital on said she recalled only that a facility staff member called her as she was coming to start her 1 pm shift and instructed her to pick up the resident. During an interview on at 2:08 pm, caregiver C said regarding the elopement that her co-worker alerted her that resident #3 could not be found in the facility. Caregiver C said both inside and outside of the facility was searched. Caregiver C said resident #3 called the administrator and described where he was. Caregiver C then got in her car and	CZ821		

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CZ821	Continued From page 23 found the resident standing on a sidewalk near the facility. The caregiver believed the resident got out when someone delivered a prescription then left the gate open. The caregiver said as a result the gate code was changed. She said the resident oftentimes says there is someone after him and he wants to go home. She said she tries to talk with him when he's like that. She said measures taken by the facility to prevent further elopements included adding an additional piece of fence to completely close in the front of the property and the administrator instructed the staff to check on the resident often to see if he's in his room or on the premises. During an interview on at 2:26 pm, caregiver B said that when the resident is , he says he wants to leave. She believed when the resident eloped on that men working on the yard left the gate open. She said the administrator met with the staff and instructed them to keep an , on the resident and she also believed his medications were adjusted. During an interview on at 10 am, the administrator said steps taken by the facility to prevent resident #3 from further eloping was the gate code was changed, the section of the unfenced property was fenced in, and staff were instructed to check on the resident more frequently during the night shift. The administrator said preliminary and final reports were not submitted to the regulatory agency for the and elopements because the resident was missing for less than 30 minutes and the elopement policy is that even if a resident is high risk for elopement, they are not considered missing until they've been gone more than three hours. The administrator believed the	CZ821		

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CZ821	Continued From page 24 required reports should have been submitted to the agency for the elopement. Unclassified	CZ821		
CZ841 SS=D	408.823( ) FS In-person Visitation (1) This section applies to , ... centers as defined in s. 393.063, hospitals licensed under chapter 395, nursing home facilities licensed under part II of chapter 400, hospice facilities licensed under part of chapter 400, intermediate care facilities for the , , licensed and certified under part VIII of chapter 400, and assisted living facilities licensed under part I of chapter 429. (2)(a) No later than 30 days after the effective date of this act, each provider shall establish visitation policies and procedures. The policies and procedures must, at a minimum, include control and education policies for visitors; screening, personal protective equipment, and other control protocols for visitors; permissible length of visits and numbers of visitors, which must meet or exceed the standards in ss. 400.022(1)(b) and 429.28(1)(d), as applicable; and designation of a person responsible for ensuring that staff adhere to the policies and procedures. Safety-related policies and procedures may not be more stringent than those established for the provider's staff and may not require visitors to submit proof of any or immunization. The policies and procedures must allow consensual physical contact between a resident, client, or patient and the visitor. (b) A resident, client, or patient may designate a visitor who is a family member, friend, guardian,	CZ841		

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CZ841	Continued From page 25 or other individual as an essential caregiver. The provider must allow in-person visitation by the essential caregiver for at least 2 hours daily in addition to any other visitation authorized by the provider. This section does not require an essential caregiver to provide necessary care to a resident, client, or patient of a provider, and providers may not require an essential caregiver to provide such care. (c) The visitation policies and procedures required by this section must allow in-person visitation in all of the following circumstances, unless the resident, client, or patient objects: 1. End-of-life situations. 2. A resident, client, or patient who was living with family before being admitted to the provider ' s care is struggling with the change in environment and lack of in-person family support. 3. The resident, client, or patient is making one or more major medical decisions. 4. A resident, client, or patient is experiencing emotional distress or grieving the loss of a friend or family member who recently . . . 5. A resident, client, or patient needs cueing or encouragement to eat or drink which was previously provided by a family member or caregiver. 6. A resident, client, or patient who used to talk and interact with others is seldom speaking. 7. For hospitals, childbirth, including labor and delivery. 8. . patients. (d) The policies and procedures may require a visitor to agree in writing to follow the provider's policies and procedures. A provider may suspend in-person visitation of a specific visitor if the visitor violates the provider's policies and procedures. (e) The providers shall provide their visitation	CZ841		

Agency for Health Care Administration

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CZ841	Continued From page 26 policies and procedures to the agency when applying for initial licensure, licensure renewal, or change of ownership. The provider must make the visitation policies and procedures available to the agency for review at any time, upon request. (f) Within 24 hours after establishing the policies and procedures required under this section, providers must make such policies and procedures easily accessible from the homepage of their websites. This Statute or Rule is not met as evidenced by: Based on review of the facility's visitation policy and procedures, review of the facility's website and interview, the facility failed to make its policy easily accessible from the homepage of its website. Findings: A review of the facility's visitation policy and procedures revealed it documented the facility would post its policy to its website on a page accessible either on or from the home page. Review of the facility's website revealed the policy was not available and accessible. On at 5 pm, the administrator confirmed the findings. Class III	CZ841		