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
	AL11953679	A. BUILDING: _____ B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH GRAND OF SARASOTA	7130 BENEVA ROAD SARASOTA, FL 34238

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A 000	Initial Comments An unannounced relicensure, emergency power plan, health facility reporting system, generator, visitation form, and complaint survey for #2022016266, #2022017247, #2023006392, #2023007209, #2023012754, #2023013317, and #2023017068 was conducted on [redacted] through [redacted] at Savannah Grand of Sarasota, an assisted living facility in Sarasota, Florida. Complaint #2022016266 was unsubstantiated. Complaint #2022017247 was substantiated without citation. Complaint #2023006392 substantiated without citation. Complaint #2023007209 was unsubstantiated. Complaint #2023012754 substantiated without citation. Complaint #2023013317 was unsubstantiated. Complaint #2023017068 was substantiated at A 081. The following is a description of the deficiencies.	A 000		
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	A 032		

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A 032	Continued From page 1	A 032		

resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 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

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A 032	Continued From page 2 manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the 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 review, and staff interview, the facility failed to complete elopement drills twice annually as required since . . . . . Further the Facility failed to ensure the elopement policies and procedures met regulatory requirements. The findings included: A review of the following policies: Strategies to Manage Elopement (No date), Identified At Risk . . . . . and/or Elopement Residents (no date), Missing Resident Protocol (no date), and Facility Elopement/Missing Resident Drill (no date) were all found to not include as part of its resident elopement response policies and procedures, the provision 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. The Facility Elopement/Missing Resident Drill (no date) did include under Procedure: 1. The Executive Director or designee will conduct an unannounced Missing Resident Drill on each shift twice annually. During an interview on at 10:20 a.m., the Resident Care Coordinator (RCC) said she started working for the facility on . She	A 032		

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A 032	Continued From page 3 said she did not participate in any elopement drills for the time she has been employed and she was not aware as of when was the last time an elopement drill was conducted. During an interview on at 11:20 a.m., caregiver/med tech Staff E said she started working in . She said she had not participated in any elopement drills, but there was one scheduled for . During an interview on at 2:00 p.m., the RCC provided the elopement drill log. The most recent elopement drill on record was dated . The RCC said she could not find any additional drills. The RCC said they were supposed to have an elopement drill on but it was canceled due to bad weather. During an interview on at 5:00 p.m., the Executive Director (ED) acknowledged the lack of elopement drills. Class III .	A 032		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another	A 078		

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A 078	Continued From page 4 when the facility is under the same management or ownership. 1. Evidence of a negative . . . . . examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual . . . . . examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . . . . . . 2. If any staff member has, or is suspected of having, a communicable . . . . . , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility . . . . . to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility	A 078		

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A 078	Continued From page 5 and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff . . . . . by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on employee record review, and interview, the facility failed to ensure that within 30 days of employment, staff submitted a written statement from a health care provider documenting the individual was free from signs/symptoms of communicable . . . . . for 5 (Staff A, B, C, D and the Executive Director [ED]) of 5 employee personnel files reviewed. The findings included: On , a review of Staff A's personnel file revealed Staff A was hired on 11/20/23. Staff A's personnel file did not contain a written statement from a health care provider documenting the individual was free from signs/symptoms of communicable . . . On , a review of Staff B's personnel file revealed Staff B was hired on . . . . . Staff B's personnel file did not contain a written statement from a health care provider documenting the individual was free from signs/symptoms of communicable	A 078		

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A 078	Continued From page 6 On . . . . . , a review of Staff C's personnel file revealed Staff C was hired on . Staff C's personnel file did not contain a written statement from a health care provider documenting the individual was free from signs/symptoms of communicable . On , a review of Staff D's personnel file revealed Staff D was hired on . . . . . Staff D's personnel file did not contain a written statement from a health care provider documenting the individual was free from signs/symptoms of communicable . . . . . . On . . . . . , a review of the ED's personnel file revealed the ED was hired on . The ED's personnel file did not contain a written statement from a health care provider documenting the individual was free from signs/symptoms of communicable . . . On at 2:35 p.m., in an interview, the ED, she confirmed her personnel file and Staff A, B, C, and D's personnel files did not contain a written statement from a health care provider documenting the individual was free from signs/symptoms of communicable . . . . . within 30 days of employment. Class III .	A 078		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011(. .) FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by	A 081		

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A 081	Continued From page 7	A 081		

the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee ' s personnel record.
(b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d).
(c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a).

(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

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A 081	Continued From page 8 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) 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	A 081		

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A 081	Continued From page 9 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. 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.	A 081		

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A 081	Continued From page 10	A 081		

This Statute or Rule is not met as evidenced by:
Based on staff interview, and employee personnel file review, the facility failed to ensure 3 of 5 facility staff had the required training within 30 days of their hire date. Review of employee files revealed no documentation that 2 Staff (B and C) had 1-hour of .... control training, 2 Staff (A and C) had 3-hours of resident behavior and needs and providing assistance with the activities of daily living within 30 days of hire. The facility also failed to ensure Staff (B) had 1 hour of training in Reporting Major Incidents, Resident Rights, nutritional and safe food handling within 30 days of hire.

The findings included:

On , a review of Staff A's personnel file with the Executive Director (ED) confirmed Staff A was hired on . Staff A's personnel file did not contain documentation they had 3 hours in-service of resident behavior and needs and providing assistance with the activities of daily living within 30 days of hire.

On , a review of Staff B's personnel file with the ED confirmed Staff B was hired on . Staff B's personnel file did not contain they had 1-hour of .... control training and 1 hour of training in Reporting Major Incidents, Resident Rights, and nutritional and safe food handling within 30 days of hire.

On , a review of Staff C's personnel file with the ED confirmed Staff C was hired on . Staff C's personnel file did not contain

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A 081	Continued From page 11 documentation they had 3 hours in-service of resident behavior and needs and providing assistance with the activities of daily living and 1 hour of control training within 30 days of hire. On at 2:45 p.m.. in an interview, the ED confirmed, after she reviewed Staff A, B, and C's personnel employee files, they were missing required documentation that Staff A, B, and C had completed the required in-services/education within 30 days of their employment. Class III	A 081		
A 083 SS=D	59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND ( ). A staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be	A 083		

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A 083	Continued From page 12 considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on staff interviews, review of facility employee working schedule, and employee file reviews, the facility failed to ensure a staff member with a certificate in First Aid were in the facility at all times. Not having a staff member certified in First Aid could lead to a delay in care and treatment for residents at the facility. The findings included: On [redacted], a review of Staff A's personnel file with the Executive Director (ED) confirmed Staff A was hired on [redacted]. Staff A's personnel file did not contain documentation that they had a certification in First Aid. On [redacted], a review of Staff C's personnel file with the ED confirmed Staff C was hired on [redacted]. Staff C's personnel file did not contain documentation that they had a certification in First Aid. On [redacted], a review of Staff D's personnel file with the ED confirmed Staff D was hired on [redacted]. Staff D's personnel file did not contain documentation that they had a certification in First Aid. On [redacted] at 2:45 p.m., in an interview, the ED said Staffs A, C and D had worked the 11:00 p.m. to 7:00 a.m. shift on [redacted], 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 19, 20, 21, 22, 25, 26, 27, 28, 29 and 30 with no other staff in the facility. On [redacted] at 2:45 p.m., in an interview, the ED confirmed after further review of the	A 083		

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A 083	Continued From page 13 schedule they did not have a facility staff employee with a valid First Aid certificate on [redacted], 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 19, 20, 21, 22, 25, 26, 27, 28, 29 and 30th working the 11:00 p.m. to 7:00 a.m. shift as required. Class III .	A 083		
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 resident chooses to eat less, the facility must serve the standard minimum portions of food	A 093		

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	AL11953679	A. BUILDING: _____ B. WING _____	01/10/2024

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A 093	Continued From page 14 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 necessary. However, the food items that enable residents to comply with the therapeutic diet must	A 093		

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A 093	Continued From page 15 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: Based on observation, and resident and staff interviews, the facility failed to have menus	A 093		

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A 093	Continued From page 16 prominently posted as required. The Facility failed to provide evidence of regular and therapeutic menus served in the last six months with substitutions noted before or when the meal was served. The findings included: On . . . . , no menu was observed posted anywhere in the facility. During an interview on at 9:40 a.m., Resident #1 said the menu was never posted, so she never knew what was served. During an interview on at 10:50 a.m., Resident #2 said that the menu was never posted, and never knew what was to be served. During an interview on at 11:00 a.m., Resident #3 said that they (residents) did not know what was being served because no menus were posted. On . . . . at 11:40 a.m., in an interview, the Dietary Manager acknowledged the menu was not posted anywhere in the facility. The Dietary Manager acknowledged that there was no record of regular and therapeutic menus served in the last six months with substitutions noted before or when the meal was served. The Dietary Manager said she was not aware of the regulatory requirement. On . . . at 3:00 p.m., in an interview, the Executive Director (ED) confirmed the menu was not prominently posted in the facility as required. The ED confirmed there was no record of regular and therapeutic menus served in the last six months with substitutions noted before or when	A 093		

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A 093	Continued From page 17 the meal was served. Class III .	A 093		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C.	A 162		

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A 162	Continued From page 18 (f) A [illegible] record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their [illegible] recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that [illegible] not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an [illegible] recipient, a copy of the Department of Children and Families form Alternate Care Certification for [illegible] ([illegible]), CF-ES 1006, [illegible], which is hereby incorporated by reference	A 162		

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A 162	Continued From page 19 and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the [illegible] of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's [illegible], DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively.	A 162		

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A 162	Continued From page 20 This Statute or Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure 1 (Resident #12) of 3 resident's contracts reviewed were retained for 5 years, and all resident records were retained for 2 years. The findings included: On . . . at 8:00 a.m., in an interview, the Resident Care Coordinator (RCC), she said she could not find all of Resident #12's medical records. She said the prior Executive Director (ED) had emailed the corporate office a portion of Resident #12's medical record, but she does not know where the prior ED had stored Resident #12's closed records. On at 10:16 a.m., in an interview, the ED and RCC said they could not find where the prior ED had stored Resident #12's contract and his medical records. Class III .	A 162		

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CZ816	408.809(2) 435.05(2) 59A-35.090(2d-3b) Background Screening-Compliance Attestation 408.809 Background screening; prohibited offenses.- (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's ␣␣␣, to the Federal Bureau of Investigation for a national criminal history record check unless the person's ␣␣␣ are enrolled in the Federal Bureau of Investigation's national retained print ␣␣␣ notification program. If the ␣␣␣ of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit ␣␣␣ electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the ␣␣␣ to the Federal Bureau of Investigation for a national criminal history record check. The ␣␣␣ shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print ␣␣␣ notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person ␣␣␣. The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or	CZ816		

AHCA Form 3020-0001

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

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CZ816	Continued From page 1	CZ816		

professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that:
(a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section;
(b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and
(c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency.

435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers:
(2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if for any of the disqualifying offenses while employed by the employer.

59A-35.090 Background Screening.
(2) Processing Screening Requests, Required Documents and Fees.
(d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, , herein incorporated by reference, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-09106, and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Service

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CZ816	Continued From page 2 s/Background_Screening/Regulations_Forms.shtml. This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if for any disqualifying offense. (e) An administrator or chief financial officer must be screened and qualified prior to to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the report and court disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to Section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with Section 435.06(3), F.S. This Statute or Rule is not met as evidenced by: Based on a review of facility personnel files and staff interview, the facility failed to obtain a signed attestation of compliance with chapter 435 Florida Statute for 4 (Staffs A, B, C and the Executive Director [ED]) of 5 employee personnel files	CZ816		

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CZ816	Continued From page 3 reviewed for compliance with background screening requirements. The findings included: On , a review of Staff A's personnel file revealed Med Tech Staff A was hired on 11/20/23. Staff A's personnel file did not contain a signed copy of their attestation. On , a review of Staff B's personnel file revealed Med Tech Staff B was hired on . Staff B's personnel file did not contain a signed copy of their attestation. On , a review of Staff C's personnel file revealed Resident Aid Staff C was hired on . Staff C's personnel file did not contain a signed copy of their attestation. On , a review of the Executive Director's personnel file revealed the ED was hired on and did not contain a signed copy of their attestation. On at 2:15 p.m., in an interview, the ED confirmed her personnel file and Staffs A, B, and C's personnel files did not contain a signed copy of compliance with chapter 435 Florida Statute form as required per law. Unclassified	CZ816		
CZ830 SS=D	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive	CZ830		

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CZ830	Continued From page 4 emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the	CZ830		

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CZ830	Continued From page 5 state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations.	CZ830		

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	AL11953679	A. BUILDING: _____ B. WING _____	01/10/2024

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CZ830	Continued From page 6 This Statute or Rule is not met as evidenced by: Based on interviews, and a review of facility records, the facility failed to ensure they reviewed their emergency management plan on an annual basis and had an approved Comprehensive Emergency Management Plan (CEMP) by the local emergency management agency on an annual basis. The findings included: On . . . . , a review of the facility's Comprehensive Emergency Management Plan (CEMP) approval letter from the county emergency management office, dated , which stated their CEMP was approved for 12 months from the date of the letter. Further review noted the facility had no documentation they had submitted their CEMP for approval prior to the . . . . . expiration date. On . . . . at 3:00 p.m., in an interview, the Executive Director (ED) confirmed their last county-approved CEMP had expired on . The ED said she and the prior ED had not completed nor submitted their CEMP to the local emergency management agency on an annual basis as required. Class III .	CZ830		

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A 000	Initial Comments An unannounced relicensure, emergency power plan, health facility reporting system, generator, visitation form, and complaint survey for #2022016266, #2022017247, #2023006392, #2023007209, #2023012754, #2023013317, and #2023017068 was conducted on [redacted] through [redacted] at Savannah Grand of Sarasota, an assisted living facility in Sarasota, Florida. Complaint #2022016266 was unsubstantiated. Complaint #2022017247 was substantiated without citation. Complaint #2023006392 substantiated without citation. Complaint #2023007209 was unsubstantiated. Complaint #2023012754 substantiated without citation. Complaint #2023013317 was unsubstantiated. Complaint #2023017068 was substantiated at A 081. The following is a description of the deficiencies.	A 000		
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	A 032		

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A 032	Continued From page 1 resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 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	A 032		

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A 032	Continued From page 2 manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the 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 review, and staff interview, the facility failed to complete elopement drills twice annually as required since . . . . . Further the Facility failed to ensure the elopement policies and procedures met regulatory requirements. The findings included: A review of the following policies: Strategies to Manage Elopement (No date), Identified At Risk . . . . . and/or Elopement Residents (no date), Missing Resident Protocol (no date), and Facility Elopement/Missing Resident Drill (no date) were all found to not include as part of its resident elopement response policies and procedures, the provision 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. The Facility Elopement/Missing Resident Drill (no date) did include under Procedure: 1. The Executive Director or designee will conduct an unannounced Missing Resident Drill on each shift twice annually. During an interview on at 10:20 a.m., the Resident Care Coordinator (RCC) said she started working for the facility on . She	A 032		

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A 032	Continued From page 3 said she did not participate in any elopement drills for the time she has been employed and she was not aware as of when was the last time an elopement drill was conducted. During an interview on at 11:20 a.m., caregiver/med tech Staff E said she started working in . She said she had not participated in any elopement drills, but there was one scheduled for . During an interview on at 2:00 p.m., the RCC provided the elopement drill log. The most recent elopement drill on record was dated . The RCC said she could not find any additional drills. The RCC said they were supposed to have an elopement drill on but it was canceled due to bad weather. During an interview on at 5:00 p.m., the Executive Director (ED) acknowledged the lack of elopement drills. Class III .	A 032		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another	A 078		

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A 078	Continued From page 4 when the facility is under the same management or ownership. 1. Evidence of a negative . . . . . examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual . . . . . examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . . . . . . 2. If any staff member has, or is suspected of having, a communicable . . . . . , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility . . . . . to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility	A 078		

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A 078	Continued From page 5 and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff . . . . . by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on employee record review, and interview, the facility failed to ensure that within 30 days of employment, staff submitted a written statement from a health care provider documenting the individual was free from signs/symptoms of communicable . . . . . for 5 (Staff A, B, C, D and the Executive Director [ED]) of 5 employee personnel files reviewed. The findings included: On , a review of Staff A's personnel file revealed Staff A was hired on 11/20/23. Staff A's personnel file did not contain a written statement from a health care provider documenting the individual was free from signs/symptoms of communicable . . . On , a review of Staff B's personnel file revealed Staff B was hired on . . . . . Staff B's personnel file did not contain a written statement from a health care provider documenting the individual was free from signs/symptoms of communicable	A 078		

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A 078	Continued From page 6 On . . . . . , a review of Staff C's personnel file revealed Staff C was hired on . Staff C's personnel file did not contain a written statement from a health care provider documenting the individual was free from signs/symptoms of communicable . On , a review of Staff D's personnel file revealed Staff D was hired on . . . . . Staff D's personnel file did not contain a written statement from a health care provider documenting the individual was free from signs/symptoms of communicable . . . . . . On . . . . . , a review of the ED's personnel file revealed the ED was hired on . The ED's personnel file did not contain a written statement from a health care provider documenting the individual was free from signs/symptoms of communicable . . . On at 2:35 p.m., in an interview, the ED, she confirmed her personnel file and Staff A, B, C, and D's personnel files did not contain a written statement from a health care provider documenting the individual was free from signs/symptoms of communicable . . . . . within 30 days of employment. Class III .	A 078		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011(. .) FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by	A 081		

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A 081	Continued From page 7	A 081		

the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee ' s personnel record.
(b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d).
(c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a).

(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

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A 081	Continued From page 8 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) 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	A 081		

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A 081	Continued From page 9 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. 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.	A 081		

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A 081	Continued From page 10	A 081		

This Statute or Rule is not met as evidenced by:
Based on staff interview, and employee personnel file review, the facility failed to ensure 3 of 5 facility staff had the required training within 30 days of their hire date. Review of employee files revealed no documentation that 2 Staff (B and C) had 1-hour of .... control training, 2 Staff (A and C) had 3-hours of resident behavior and needs and providing assistance with the activities of daily living within 30 days of hire. The facility also failed to ensure Staff (B) had 1 hour of training in Reporting Major Incidents, Resident Rights, nutritional and safe food handling within 30 days of hire.

The findings included:

On , a review of Staff A's personnel file with the Executive Director (ED) confirmed Staff A was hired on . Staff A's personnel file did not contain documentation they had 3 hours in-service of resident behavior and needs and providing assistance with the activities of daily living within 30 days of hire.

On , a review of Staff B's personnel file with the ED confirmed Staff B was hired on . Staff B's personnel file did not contain they had 1-hour of .... control training and 1 hour of training in Reporting Major Incidents, Resident Rights, and nutritional and safe food handling within 30 days of hire.

On , a review of Staff C's personnel file with the ED confirmed Staff C was hired on . Staff C's personnel file did not contain

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A 081	Continued From page 11 documentation they had 3 hours in-service of resident behavior and needs and providing assistance with the activities of daily living and 1 hour of control training within 30 days of hire. On at 2:45 p.m.. in an interview, the ED confirmed, after she reviewed Staff A, B, and C's personnel employee files, they were missing required documentation that Staff A, B, and C had completed the required in-services/education within 30 days of their employment. Class III	A 081		
A 083 SS=D	59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND ( ). A staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be	A 083		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 083	Continued From page 12 considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on staff interviews, review of facility employee working schedule, and employee file reviews, the facility failed to ensure a staff member with a certificate in First Aid were in the facility at all times. Not having a staff member certified in First Aid could lead to a delay in care and treatment for residents at the facility. The findings included: On [redacted], a review of Staff A's personnel file with the Executive Director (ED) confirmed Staff A was hired on [redacted]. Staff A's personnel file did not contain documentation that they had a certification in First Aid. On [redacted], a review of Staff C's personnel file with the ED confirmed Staff C was hired on [redacted]. Staff C's personnel file did not contain documentation that they had a certification in First Aid. On [redacted], a review of Staff D's personnel file with the ED confirmed Staff D was hired on [redacted]. Staff D's personnel file did not contain documentation that they had a certification in First Aid. On [redacted] at 2:45 p.m., in an interview, the ED said Staffs A, C and D had worked the 11:00 p.m. to 7:00 a.m. shift on [redacted], 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 19, 20, 21, 22, 25, 26, 27, 28, 29 and 30 with no other staff in the facility. On [redacted] at 2:45 p.m., in an interview, the ED confirmed after further review of the	A 083		

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A 083	Continued From page 13 schedule they did not have a facility staff employee with a valid First Aid certificate on [redacted], 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 19, 20, 21, 22, 25, 26, 27, 28, 29 and 30th working the 11:00 p.m. to 7:00 a.m. shift as required. Class III .	A 083		
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 resident chooses to eat less, the facility must serve the standard minimum portions of food	A 093		

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A 093	Continued From page 14	A 093		

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 necessary. However, the food items that enable residents to comply with the therapeutic diet must

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A 093	Continued From page 15 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: Based on observation, and resident and staff interviews, the facility failed to have menus	A 093		

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A 093	Continued From page 16 prominently posted as required. The Facility failed to provide evidence of regular and therapeutic menus served in the last six months with substitutions noted before or when the meal was served. The findings included: On . . . . , no menu was observed posted anywhere in the facility. During an interview on at 9:40 a.m., Resident #1 said the menu was never posted, so she never knew what was served. During an interview on at 10:50 a.m., Resident #2 said that the menu was never posted, and never knew what was to be served. During an interview on at 11:00 a.m., Resident #3 said that they (residents) did not know what was being served because no menus were posted. On . . . . at 11:40 a.m., in an interview, the Dietary Manager acknowledged the menu was not posted anywhere in the facility. The Dietary Manager acknowledged that there was no record of regular and therapeutic menus served in the last six months with substitutions noted before or when the meal was served. The Dietary Manager said she was not aware of the regulatory requirement. On . . . at 3:00 p.m., in an interview, the Executive Director (ED) confirmed the menu was not prominently posted in the facility as required. The ED confirmed there was no record of regular and therapeutic menus served in the last six months with substitutions noted before or when	A 093		

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A 093	Continued From page 17 the meal was served. Class III .	A 093		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C.	A 162		

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A 162	Continued From page 18 (f) A [illegible] record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their [illegible] recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that [illegible] not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an [illegible] recipient, a copy of the Department of Children and Families form Alternate Care Certification for [illegible] ( ), CF-ES 1006, [illegible], which is hereby incorporated by reference	A 162		

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A 162	Continued From page 19 and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the [illegible] of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's [illegible], DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively.	A 162		

Agency for Health Care Administration

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A 162	Continued From page 20 This Statute or Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure 1 (Resident #12) of 3 resident's contracts reviewed were retained for 5 years, and all resident records were retained for 2 years. The findings included: On . . . at 8:00 a.m., in an interview, the Resident Care Coordinator (RCC), she said she could not find all of Resident #12's medical records. She said the prior Executive Director (ED) had emailed the corporate office a portion of Resident #12's medical record, but she does not know where the prior ED had stored Resident #12's closed records. On at 10:16 a.m., in an interview, the ED and RCC said they could not find where the prior ED had stored Resident #12's contract and his medical records. Class III .	A 162		