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
	AL11953368	A. BUILDING: _____ B. WING _____	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAPLES GREEN VILLAGE	101 CYPRESS WAY EAST NAPLES, FL 34110

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A 000	Initial Comments An unannounced relicensure, extended congregate care, emergency power plan, health facility reporting system, generator, visitation form, and complaint survey for #2022007604, #2022008012, #2022017250, #2023005784, #2023010497, and #2023014581 was conducted on through at Naples Green Village, an assisted living facility in Naples, Florida. Complaint #2022007604 was substantiated at A032. Complaint #2022008012 was substantiated at A025 and A032. Complaint #2022017250 was substantiated at A091, A092, and A093. Complaint #2023005784 was substantiated at A025 and A032. Complaint #2023010497 was substantiated at A025. Complaint #2023014581 was substantiated at A092. The following is a description of the deficiencies.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the	A 025		

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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 resident is discharged or moves out.
(f) Maintaining a written record, updated as needed, of any significant changes, any illnesses

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that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services.

This Statute or Rule is not met as evidenced by:
Based on observation, interview, and record review the facility failed to provide adequate supervision to prevent for 6 residents (#13, #20, #21, #3, #26, and #24) of 5 residents reviewed for .

The findings included:

The policy titled " Management Program" effective was provided. The policy overview said, " This policy focuses on two primary approaches to the management of and injuries. The first is through an immediate response to residents who . The second approach is long-term management. Our overall goal of this policy is to identify residents at risk for and injury and to consider interventions to mitigate the risk of and injury."

Interventions: "Residents who have been identified as a risk by either their physician, having a score of 10 or higher, has had a recent with an injury, or has had two or more within the same month will be entered in to the " on Me" management program and have individualized interventions included on their personal assessment care plan.

Evaluations: a " Risk Evaluation form must be completed on every new resident upon move-in ..."
If a resident is identified as a risk by a score of 10 or greater on the risk evaluation form, the

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resident will be entered into the " , on Me" management program. Enter their name on the FMP entry log and keep this log in a binder in the Wellness Directors Office.

Resident records were reviewed.

1. Resident #13 was admitted to the memory care unit on with a diagnosis of . The 1823 dated diagnosis included and noted resident requires a wheelchair for mobility. Special precautions noted " ". The 1823 specified Resident #13 required assistance with all activities of daily living.

No evaluation was provided. Resident #13 was not admitted to the " , on Me" management program.

The incident log noted Resident #13 had a witnessed in her bedroom that resulted in a on at 11:15 a.m. There was no documentation of any new or changed interventions to prevent further .

The incident log noted Resident #13 had an unwitnessed, reported in her bedroom on at 4:35 p.m. There was no documentation of any new or changed interventions to prevent further .

The incident log noted Resident #13 had a in her bedroom on at 1:00 p.m., noted to have , and . No other information provided. There was no documentation of any new or changed interventions to prevent further .

The incident log noted Resident #13 had a

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A 025	Continued From page 4 in her bedroom on . . . . . as an "unwitnessed reported , with a . , cut, ." There was no documentation of any new or changed interventions to prevent further . The incident log noted Resident #13 had a in her bedroom on at 9:30 p.m. and was "observed on floor." There was no documentation of any new or changed interventions to prevent further . The incident log noted Resident #13 had a in her bedroom on at 8:10 a.m. and was "observed on floor." There was no documentation of any new or changed interventions to prevent further . . The incident log noted Resident #13 had a in her bedroom on . . . . . at 9:45 p.m. and was "observed on floor." The resident was sent to the hospital for evaluation and was diagnosed with a T11 . Resident #13 returned to the facility on . . . . . with hospice services in place. The intervention implemented was for the "community to complete evaluations and level of care evaluations upon admission, 30 days, 60 days, and change of condition." 2. Resident #20 was admitted to the facility on with the diagnosis of . She resided in the memory care unit. On at 4:48 p.m., staff reported Resident #20 slipped and while staff were providing care resulting in a left , ( ) . . . . . and left . . . . . . Facility investigation noted Resident #20 had a witnessed in her room while being assisted by a caregiver. Facility investigation noted the wet floor was a contributing factor to the . Resident #20 did not	A 025		

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A 025	Continued From page 5 return to the facility. No evaluation form was provided. 3. Resident #21 was admitted to the facility on . Her diagnoses included . The admission 1823 dated noted Resident #21 was at high risk for , and required assistance with bathing, and supervision for all other activities of daily living. Resident #21 was found on the floor on in her bedroom. The facility investigation noted the resident did not appear to have any injuries. On the resident complained of , and was present. A portable was obtained that showed a and the resident was transferred to the hospital and did not return to the facility. No changes to the care plan were made and there was no documentation of increased supervision after the on . No evaluation form was provided. Resident #21 was not admitted to the " on Me" management program. 4. Resident #3 was admitted to the facility on and resided in the memory care unit. Her diagnoses included . The clinical record review noted multiple . On at 7:30 a.m., Resident #3 had an unwitnessed reported that resulted in a . On at 11:45 a.m., Resident #3 had an alleged . On at 12:30 p.m., Resident #3 had a	A 025		

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A 025	Continued From page 6 witnessed in the hallway. On at 7:15 p.m., Resident #3 was involved in a resident-to-resident altercation in the activity area. On at 12:40 p.m., Resident #3 was observed on the floor in her bathroom. On at 1:30 p.m., Resident #3 was observed on the floor in her bedroom. On at 1:55 p.m., Resident #3 had an unwitnessed reported in the hallway. evaluation forms dated was scored at 13 points, was scored at 10 points, was scored at 10 points. The resident was not admitted to the "on Me" management program. 5. Resident #26 was admitted to the facility on . Her diagnoses included . The 1823 dated noted Resident #26 had poor gait, and mild . Supervision was required for ambulation, toileting and transferring. The 1823 updated noted Resident #26 required special precautions for . She needed assistance with all activities of daily living including transferring and ambulation. The service plan dated noted the resident required "1 on physical assist." The risk evaluation forms dated scored 13 points, scored 13 points, scored 11 points, scored 12 points. The resident was not admitted to the " on	A 025		

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A 025	Continued From page 7 Me" program. On . . . . . at 12:30 p.m.,Resident #26 had an unwitnessed reported in the activity room. On at 5:30 p.m., Resident #26 was observed on the hallway floor. On . . . . . at 6:50 p.m. Resident #26 was observed on the hallway floor with a . at 10:15 a.m., Resident #26 had an unwitnessed . in the activity room. . . . . . at 3:30 p.m., Resident #26 was found on the hallway floor, after an unwitnessed reported . . On . . . . . at 4:30 p.m., Resident #26 was observed on the dining room floor. On . . . . . at 9 a.m., Resident #26 was noted to have an . . . . . and . . . just below right . On . . . . . at 11:40 a.m., Resident #26 was involved in a resident-to-resident altercation. On . . . . . at 7:27 p.m., Resident #26 had an unwitnessed reported in the hallway. On . . . . . at 6:00 p.m., Resident #26 was observed on the hallway floor. On . . . . . 2:00 p.m., Resident #26 was observed on the bedroom floor with a . . . . . . On . . . . . 1:00 p.m., Resident #26 had an unwitnessed in the hallway.	A 025		

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A 025	Continued From page 8 On at 3:00 p.m., Resident #26 had an unwitnessed in the act room. On at 2 p.m. Resident #26 was observed on the dining room floor. On 8:30 a.m. Resident #26 had a witnessed in the dining room. On at 4:00 p.m., Resident #26 had an unwitnessed in in her bedroom. On at 2:35 p.m., Resident #26 was observed on the floor and complained of , On at 12:30 p.m., Resident #26 had an unwitnessed in the dining room. On at 2:30 p.m., Resident #26 had an unwitnessed reported in her bedroom. On at 8:11 a.m., Staff K, facility care partner said when someone we call the nurse but there is nothing special we do for them. I know of 2 residents that are increased risks. On at 9:53 a.m., Staff I said there is no list of residents that are at an increased risk. I'm not familiar with the " on Me" program. There are no specific interventions in place for residents at increased risk and there is nothing documented that they are at increased risk for . On at 2:27 p.m., the Director of Nursing said, "What we usually do for every is see where they are, we try to keep them busy with activities, trying to keep them in the common area, we may add something like safety checks.	A 025		

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A 025	Continued From page 9 They get up and ." On at 4:00 p.m., the Executive Director said for Resident # 3, "We try to keep her busy. It's not like there are not rounds being done on her. We give her things to do but she gets agitated." Her frequency of checks includes, "always around staff as much as possible" and at night she is checked every two hours. The Executive Director (ED) verified the policy is what has been in use and is current as of today. The expectation is that the Director of Nursing implements the management program and ' on me' program. Unless there were new orders or injuries, there would not be individual interventions put in place. If we notice are recurring, we try to figure out what we can do. is available on site through a third party provider but they do not give us a copy of the screening and they do not screen everyone after they . The ED said we have not implemented the ' on Me' since I've been here, . We do not have any other policy or management program. Our interventions are to keep them busy, initiate a toileting schedule, some of them are referred to . No specific interventions have been implemented following the of resident #26, #21, #20 or 13. On at 11:45 a.m., the DON said she did not have any documentation of training for the ' on me' management program and has not used the program. Staff have not been trained about the program. 6. On , review of a progress note dated for Resident #24 showed that, "Resident had a previous a few days ago with noted to area." The resident was then sent out to	A 025		

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A 025	Continued From page 10 the emergency room for evaluation. The progress note on stated that the facility received a message from the emergency department which indicated that the resident had a left . During an interview on at 2:26 p.m., the Director of Nursing (DON) stated that Resident #24 was found sitting on the floor next to her bed in the morning. She was unable to tell staff what happened, and the nurse observed a large on her left . No other injuries were found. She stated that the resident was monitored and there were no complaints from the resident at that point. Some was noted a few days later, and they sent her to the ER for evaluation. The resident was admitted to the hospital. A left was diagnosed. The DON stated that the resident returned to the facility on after being in a skilled nursing facility and is now using her wheelchair more and requires more assistance.	A 025		
A 026 SS=D	59A-36.007(2) FAC Resident Care - Social & Leisure Activities (2) SOCIAL AND LEISURE ACTIVITIES. Residents shall be encouraged to participate in social, recreational, educational and other activities within the facility and the community. (a) The facility must provide an ongoing activities program. The program must provide diversified individual and group activities in keeping with each resident's needs, abilities, and interests. (b) The facility must consult with the residents in selecting, planning, and scheduling activities. The facility must demonstrate residents' participation through one or more of the following methods: resident meetings, committees, a resident	A 026		

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council, a monitored suggestion box, group discussions, questionnaires, or any other form of communication appropriate to the size of the facility.
(c) Scheduled activities must be available at least 6 days a week for a total of not less than 12 hours per week. Watching television is not an activity for the purpose of meeting the 12 hours per week of scheduled activities unless the television program is a special one-time event of special interest to residents of the facility. A facility whose residents choose to attend day programs conducted at adult day care centers, senior centers, mental health centers, or other day programs may count those attendance hours towards the required 12 hours per week of scheduled activities. An activities calendar must be posted in common areas where residents normally congregate.
(d) If residents assist in planning a special activity such as an outing, seasonal festivity, or an excursion, up to 3 hours may be counted toward the required activity time.

This Statute or Rule is not met as evidenced by:
Based on observation, interviews with the life enrichment coordinator and memory care resident care staff the facility failed to provide activities on in the designated memory care portion of the facility per state guidelines and company policy.

The Findings included:

On at 10:17 a.m., 22 residents were observed in the dining room of the memory care unit sitting at the dining room tables and eating cups yogurt while listening to a DVD entitled "Oldies but Goodies music from 1970" on the TV. The caregivers appeared to be passing out yogurt

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cups. No interaction was witnessed taking place between the residents and staff while the residents ate.

On ..... at 2:00 p.m., 19 residents were observed in the dining room and 4 of those residents were asleep while Christmas music played on the TV. A care staff employee was cleaning the dining room following lunch.

On ..... at 2:45 p.m., 9 residents were observed gathered in what appeared to be a lounge area in the memory care section of the facility. Residents were sitting in chairs while a children's cartoon movie played on the TV. The care giver did not know the name of the movie. Staff members were not interacting with the residents in the room. The care giver was not able to say what the residents should be doing. The activity calendar stated that massages were scheduled for 2:00 p.m. and bowling was scheduled for 3:30 p.m.

On 1/29/24 at 3:33 p.m. in an interview, the Medication Technician stated that the life enrichment coordinator was never there on Mondays and the care staff on duty do whatever they can for residents when they have time.

On at 3:45 p.m. in an interview, the staff nurse confirmed that the life enrichment coordinator was not there that day and said they try to follow what activities are scheduled for that day in-between providing care for the residents. She stated they don't always have time to do what is scheduled and try to fill in with what activities they can do if they have time.

On at 1:00 p.m. in an interview, the life enrichment coordinator confirmed that neither

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A 026	Continued From page 13 she nor the assistant life enrichment coordinator worked on . The life enrichment coordinator stated that when the life enrichment staff is not at work, it is the care staff's responsibility to get into the activity room cabinets and use supplies to come up with ideas to do with the residents as time allows during their shift. On at 3:00 p.m., review of the facility policy, "Life Enrichment Program Standards" states the facility is to provide a minimum of 4 programs a day, 7 days a week, 365 days per year including at least 3 evening programs. A Review of the State of Florida assisted living code outlines that Florida assisted living facilities are required to provide residents with opportunities to participate in recreational, social, educational, and other facility and community activities. These activities should be available for at least six days a week and no less than 12 hours.	A 026		
A 030 SS=D	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility	A 030		

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policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint.
(c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and ;
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and standard precautions;
8. The requirements for coordinating the delivery of services to residents by third party providers;
9. Assistive devices; and
10. Physical .
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own

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sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside.

429.28 Resident bill of rights.-
(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:
(a) Live in a safe and decent living environment, free from and neglect.
(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.
(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.
(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and

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visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.
(e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community.
(f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a room with his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community.
(k) At least 45 days' notice of relocation or

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termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.

(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.

(2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the

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State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida.

429.27 Property and personal affairs of residents.-
(1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs.
(b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe

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A 030	Continued From page 19 management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation, and interview the facility failed to ensure residents had access to a telephone to facilitate the residents right to unrestricted and private communication. The facility also failed to have the Resident Bill of Rights provided by the Long Term Care Ombudsman Program posted in full view. The telephone number for lodging complaints against a facility or facility staff was not posted in the secured memory care area. The findings included: On . . at 12:00 p.m., a tour of the secured memory care was conducted. There was no Resident Bill of Rights posted in any area of the memory care. The telephone number for lodging complaints against the facility or staff was not posted, information regarding resident rights or and neglect was not posted, and there was no community phone for residents to use in a private area. On at 2:15 p.m., Licensed Practical Nurse Staff J said if the resident wanted to make or receive a phone call the resident would be assisted to the nursing station and staff would need to remain with them because of the medical records and medications kept in the room. On . . . . . at 5:13 p.m., the Executive Director verified there was no Ombudsman poster displayed or resident information posted in the secured memory care area and there was no	A 030		

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A 030	Continued From page 20 telephone available for private phone calls.	A 030		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 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	A 032		

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admission. The photo identification may be provided by the facility, the resident, or the resident's representative.
(b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for:
1. An immediate search of the facility and premises,
2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities,
3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and,
4. The continued care of all residents within the 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 observation, record reviewed, and staff interview facility failed to ensure that residents who were identified as elopement risk had identification on their persons that included their name and the facility's name, address, and telephone number. Facility failed to follow it is policy and procedure related to elopement risk.

Findings included:

Requested and received the policy named: Elopement Risk. Effective . . . . . Policy

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A 032	Continued From page 22 Overview: It is the policy of Concordis Senior living to ensure the safety of all residents. Residents who are at risk for elopement should be identified. Policy details: 1) Residents at designated memory care community or memory care unit shall be considered at risk for elopement. 2) Those residents identified as at risk of elopement should wear identification containing the residents's name and the community name, address and telephone number. 3) Residents identified at risk of elopement should be checked daily to determine that they have their identification on them. 4) If ,during the daily check, the resident is not wearing his or her identification, it should be noted in the residents medical record. Alternate options of identification will be explored for those residents who repeatedly do not have their identification on them or who refuse to wear them. On at 11:00 a.m., the administrator said that all 37 residents in the memory unit were deemed as elopement risk. On at 12:00 noon during meal observation, all 37 residents in memory the unit were observed having lunch. Only 3 out of the 37 residents had identification on their person. On at 12:22 p.m., Staff A said, " No one here is elopement risk. They don't wear their identification. They like to take them off. " On at 12:24 p.m., Staff B said, " Residents don't like to wear the ID (identification) and they take it off." On at 12:30 p.m., Staff C said, " No one here is elopement risk. They don't like to wear	A 032		

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A 032	Continued From page 23 the ID. They take them off. " On [redacted] at 12:37 p.m., Staff D said, " They are not elopement risks. They don't like to wear their ID. We try to put it on but they remove it. " On [redacted] at 1:25 p.m., Administrator said, " I am very surprised they told you they don't know that all residents in the memory unit are elopement risk. I need to re-train them. I need to make sure they are wearing their identification. I will talk to them again so they can check on the residents to ensure they are wearing identification all the time. I am very surprised." During a follow up interview with administrator on [redacted] at 3:29 p.m., she confirmed the staff did not follow facility's procedure and check on all residents that are deemed as high risk of elopement in order to ensure they were having their identification on their person. Class III	A 032		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011([redacted]) 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 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.	A 081		

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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 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

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A 081	Continued From page 25 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 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.	A 081		

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A 081	Continued From page 26 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. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure facility employees complete the in-service training required by Florida Administrative Code within 30 days of	A 081		

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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 081	Continued From page 27	A 081		

employment for 3 (Staff D, E, and F) of 4 employee files reviewed. The facility failed to ensure facility employees had 1 hour of , neglect and , training as required for 7(Staff C, D, E, F, L, M, and N) of 10 employees sampled for training.

The findings included:

Record review found Staff D was hired on as a Resident Aide/Care Partner. Further review of staff D's file revealed:
Certificate of completion on for 1 hour of Empowering Residents through ADLs and behavioral needs training;
Certificate of completion on for 30 minutes of care - Challenging Behaviors and Direct Care staff (regulation requires 3 hours).
Certificate of completion on for 30 minutes of Elopement Policy and Response.
Certificate of completion on for 30 minutes of Preventing, Recognizing, and Reporting (regulation requires 1 hour).
The training was completed online through a commercial computer training system and was not specific to facility policies.

Record review found Staff E was hired on as a Care Partner. Further review of staff E's file revealed:
Certificate of completion dated for 30 minutes of Preventing, Recognizing and Reporting .
Certificate of completion dated for 30 minutes of Managing Development (regulation requires 1 hour).
The training was completed online through a commercial computer training system and was not specific to facility policies.
Certificates of completion on for 1 hour of

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A 081	Continued From page 28 training for Empowering Residents through ADLs; 30 minutes each of training for Care, and Performing ADLs on (regulation requires 3 hours). Record review found Staff F was hired on as a Care Partner. Further review of staff F's record revealed: Certificate of completion dated for 30 minutes of Preventing, Recognizing and Reporting . Certificate of completion dated for 30 minutes of Managing Elopement (regulation requires 1 hour). The training was completed online through a commercial computer training system and was not specific to facility policies. Certificate of completion dated for 1 hour of Empowering Residents through ADLs (regulation requires 3 hours). Review of Staff C's record revealed 30 minutes of training for Preventing, Recognizing and Reporting completed on (regulation requires 1 hour of training). Review of Staff L's record revealed 30 minutes of training for Preventing, Recognizing and Reporting completed on . Review of Staff M's record revealed 30 minutes of training for Preventing, Recognizing and Reporting completed on . Review of Staff N's record revealed 30 minutes of training for Preventing, Recognizing and Reporting completed on . On at 1:38 p.m., the Business Office Manager and Executive Director confirmed the	A 081		

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A 081	Continued From page 29 training does not meet regulation requirements as they were not 1 hour and were not facility specific. Class III	A 081		
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 and related ; 2. Characteristics of ; 3. Communicating with residents with ; 4. Family issues; 5. Resident environment; and,	A 086		

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A 086	Continued From page 30 6. Ethical issues. (b) Staff who have successfully completed both the initial one hour and continuing three hours of ADRD training pursuant to sections 400.1755, 429.917 and 400.6045(1), F.S., shall be considered to have met the initial assisted living facility and Related Level I Training. (c) Facility staff who provide direct care to residents with ADRD must obtain an additional 4 hours of training, entitled " and Related Level II Training," within 9 months of employment. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. and Related Level II Training must address the following subject areas as they apply to these : 1. Behavior management, 2. Assistance with ADLs, 3. Activities for residents, 4. Stress management for the care giver; and, 5. Medical information. (d) A detailed description of the subject areas that must be included in an ADRD curriculum which meets the requirements of paragraphs (a) and (b) of this subsection, can be found in the document "Training Guidelines for the Special Care of Persons with 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	A 086		

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A 086	Continued From page 31	A 086		

required by section 429.52, F.S., and subsection (1) of this rule, or 3 of the 6 hours of continuing education for extended congregate care required by subsection (7) of this rule.
(f) Facility staff who have only incidental contact with residents with ADRD must receive general written information provided by the facility on interacting with such residents, as required under section 429.178, F.S., within three (3) months of employment. "Incidental contact" means all staff who neither provide direct care nor are in regular contact with such residents.
(g) Persons who seek to provide ADRD training in accordance with this subsection must provide the department or its designee with documentation that they hold a Bachelor's degree from an accredited college or university or hold a license as a registered nurse, and:
1. Have 1 year teaching experience as an educator of caregivers for persons with or related , or
2. Three years of practical experience in a program providing care to persons with or related , or
3. Completed a specialized training program in the subject matter of this program and have a minimum of two years of practical experience in a program providing care to persons with or related .
(h) With reference to requirements in paragraph (g), a Master's degree from an accredited college or university in a subject related to the content of this training program can substitute for the teaching experience. Years of teaching experience related to the subject matter of this training program may substitute on a year-by-year basis for the required Bachelor's degree referenced in paragraph (g).

This Statute or Rule is not met as evidenced by:

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A 086	Continued From page 32 Based on record review and interview the facility failed to ensure employees complete 4 hours of Level I trainings within 3 months of hire and 4 hours of Level II training within 9 months of hire as required for 2 (Staff D, and E) of 4 employees reviewed. The findings included: Record review found Staff D was hired on as a Resident Aide/Care Partner. Further review found no evidence of completion of 4 hours of training Level I within 3 months of hire. Record review found Staff E was hired on as a Care Partner. Further review found no evidence of completion of 4 hours of training Level I within 3 months of hire, and no evidence of completion of 4 hours of training Level II within 9 months of hire as required. On at 1:38 p.m., the Business Office Manager confirmed the findings. Class III	A 086		
A 091 SS=D	59A-36.011(12) FAC Training - Documentation & Monitoring (12) TRAINING DOCUMENTATION AND MONITORING. (a) Except as otherwise noted, certificates, or copies of certificates, of any training required by this rule must be documented in the facility's personnel files. The documentation must include the following:	A 091		

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A 091	Continued From page 33 1. The title of the training program, 2. The subject matter of the training program, 3. The training program agenda, 4. The number of hours of the training program, 5. The trainee's name, dates of participation, and location of the training program, 6. The training provider's name, dated signature and credentials, and professional license number, if applicable. (b) Upon successful completion of training pursuant to this rule, the training provider must issue a certificate to the trainee as specified in this rule. (c) The facility must provide the Department of Elder Affairs and the Agency for Health Care Administration with training documentation and training certificates for review, as requested. The department and agency reserve the right to attend and monitor all facility in-service training, which is intended to meet regulatory requirements. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to appropriately document required trainings for 3 (Staff D, E, and F) of 4 employee records reviewed. The findings include: Record review for Staff D revealed a hire date of as a Medication Technician. Further review revealed a certificate of completion dated for training on and Advanced Directives Policy. The certificates did not include, the agenda, instructors signature and credentials, and location of the training. Record review for Staff E revealed a hire date of as a Care Partner. Further review	A 091		

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A 091	Continued From page 34 revealed a certificate of completion dated for training on and Advanced Directives Policy. The certificates did not include, the agenda, instructors signature and credentials, and location of the training Record review for Staff F revealed a hire date of as a Care Partner. Further review revealed a certificate of completion dated for training on and Advanced Directives Policy. The certificates did not include, the agenda, instructors signature and credentials, and location of the training On at 1:38 p.m., the Business Office Manager acknowledged the certificates do not meet regulation, as they do not include the trainers name, credentials, signature and an agenda. Class III	A 091		
A 092 SS=D	59A-36.012(1) FAC Food Service - General Responsibilities (1) GENERAL RESPONSIBILITIES. When food service is provided by the facility, the administrator, or an individual designated in writing by the administrator, must be responsible for total food services and the day-to-day supervision of food services staff. In addition, the following requirements apply: (a) If the designee is an individual who has not completed an approved assisted living facility core training course, such individual must complete the food and nutrition services module of the core training course before assuming responsibility for the facility's food service. The	A 092		

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A 092	Continued From page 35	A 092		

designee is not subject to the 1 hour in-service training in safe food handling practices.
(b) If the designee is a certified food manager, certified dietary manager, registered or licensed dietitian, dietetic registered technician, or health department sanitarian, the designee is exempt from the requirement to complete the food and nutrition services module of the core training course before assuming responsibility for the facility's food service as required in paragraph (1)(a) of this rule.
(c) An administrator or designee must perform his or her duties in a safe and sanitary manner.
(d) An administrator or designee must provide regular meals that meet the nutritional needs of residents, and therapeutic diets as ordered by the resident's health care provider for residents who require special diets.
(e) An administrator or designee must comply with the food service continuing education requirements specified in rule 59A-36.011, F.A.C.

This Statute or Rule is not met as evidenced by:
Based on observation, interview, and record review the facility failed to ensure the Dinning Director performed his duties in a sanitary manner. The facility also failed ensure the meals met the nutritional needs of the residents and failed to ensure a therapeutic diet was prepared and served as ordered by the health care provider for 1 (Resident #13) of 5 residents reviewed. The facility failed to document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal.

The findings included:

1. On at 8:30 a.m., observed the Dining Director preparing plates for the dining room

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A 092	Continued From page 36	A 092		

service. The Dining Director has a beard and was not wearing a beard guard.

On at 8:35 a.m., the Dining Director confirmed he is required to wear a beard guard and acknowledged that he was not wearing a beard guard.

On at 9:06 a.m. in an interview, the Executive Director confirmed the Dining Director has a beard and is required to wear a beard guard when prepping and serving meals.

The Dietary Policy overview revised on states the facility "provides meals that meet the nutritional needs of the residents and offer therapeutic diets as ordered by the physician..."

2. On at 11:53 a.m., 3 aides were observed pouring lemonade, tea, cranberry juice, and water for residents. Residents were not given the choice of beverage and staff verified the juice beverages were not sugar free. They confirmed there is sugar free available in the kitchen, but it is not served in memory care. Those residents on , -controlled diets or diets were served the same beverages.

3. Review of the record reveals Resident #13 was admitted to the facility on . The diagnoses included . The admission Health Assessment - Form 1823 (1823) indicated the resident was on a regular diet. The 1823 updated on noted the resident was admitted to hospice services and required a pureed diet. The record review noted a dietary communication form, not dated, which indicated the resident was on a pureed texture diet. A review of the Addendum Plan of Care/Recert, updated

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A 092	Continued From page 37 comprehensive assessment dated . . . , noted Resident #13 required a pureed diet. On at 12:35 p.m., Resident #13 was observed being fed lunch. The caregiver said the resident was not able to eat much; only about 10%. On . . . . . at 12:45 p.m., Resident #13 was observed being fed lunch by her husband. Her husband was overheard telling the resident she needed to chew her food. Resident #13's husband said she was not able to eat much of the chicken and tomatoes. (Photographic evidence obtained) On . . . . at 4:00 p.m., the Director of Nursing (DON) said the resident was started on a pureed diet, but the husband said he preferred that the resident have a mechanical or regular diet. The DON said she did not know who the husband communicated this information to because it was not documented in the record. The DON also said there was no documentation that the risk of choking was explained to the spouse. The DON said there was no documentation that the hospice nurse or the hospice physician were informed the spouse preferred a non-pureed diet for his wife. The DON stated, "A diet order change should have been obtained and recorded in the progress notes." On at 4:15 p.m., the Executive Director said we follow all physician orders. If the hospice provider changed the diet order the DON should be communicating a change of orders or plan of care. I know the hospice providers stop in the office and update the DON after their visits. Class III	A 092		

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A 093	Continued From page 38	A 093		
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 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	A 093		

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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 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.

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A 093	Continued From page 40 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, interview, and record review the facility failed to ensure menus were easily available to residents. The facility failed to ensure no more than 14 hours elapsed between the end of an evening meal and the beginning of a morning meal. The facility failed to ensure food was served at safe and palatable temperatures and all residents had a supply of eating ware sufficient to consume the meal being served. The findings included:	A 093		

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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 093	Continued From page 41 A review of the Resident Council Meeting minutes for 2023 found residents expressed concerns regarding food: In residents verbalized concern that the "daily menu is not always updated on the board". In , residents verbalized concerns that breakfast was identified to start at 8:00 a.m., but was not delivered to the dining room until 8:30 a.m. In , residents verbalized concerns again about breakfast not being delivered to dining room tables until 8:30 or 8:45 a.m. and said Lunch and Dinner are also delivered late. In the minutes again reflected concerns regarding dining room mealtimes. In , residents still expressed concern about breakfast times. 1. On at 10:30 a.m., the memory care unit's daily menu was observed posted in the dining room with the date for 'Today's Menu' Saturday, . The posted 'Weekly Menu' was dated for "Sun through Sat ". On at 12:25 p.m., Lunch service was observed in the memory care unit. The menu, posted in a difficult to reach corner above , level was dated . The menu was not current. No choices or options provided. (Photographic Evidence Obtained) 2. On at 8:15 a.m., while touring with the Executive Director (ED), the breakfast food cart was observed sitting in the memory care dining room waiting for staff to serve residents. The Executive Director stated breakfast is served at 8:00 a.m., lunch at 12:00 p.m. and dinner at 5:00 p.m.	A 093		

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	AL11953368	A. BUILDING: _____ B. WING _____	01/30/2024

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A 093	Continued From page 42 On . . . . . at 8:21 a.m., the food cart with the breakfast meals remained stationed in the dining room; no residents had been served breakfast. Staff G said breakfast starts at 8:00 a.m.; the food cart with the meals comes from the kitchen and the staff serves the meals in the dining room, On . . . . . at 8:27 a.m., staff were observed passing orange juice and distributing napkins. The hot food cart had not yet been opened. On . . . . . at 8:37 a.m., the aides in the dining room were observed setting the tables. On . . . . . at 8:40 a.m., the first breakfast tray was served; 40 minutes after delivery of the food cart to the memory care unit. On . . . . . at 9:45 a.m., the ED said all meals usually last about 45 minutes, she stated some residents are finished eating in about 30-35 minutes in the memory care dining room. On . . . . . at 1:15 p.m. in an interview, the Dining Director stated that service of the evening meal was completed by 5:40 p.m. each day and the morning meal begins at 8:00 a.m. each day. On . . . . . the breakfast meal was served at 8:40 a.m.; 15 hours from the expected end of the dinner meal. On . . . . . at 4:10 p.m., the Executive Director stated she cannot say for certain snacks are being offered at night at 7:00 p.m.; the expected time to be offered. The ED confirmed if no snacks are offered at 7:00 p.m., there is more than a 14-hour elapse of time between the evening meal and the breakfast meal. The Executive Director said, " I will have to adjust the mealtimes on the menus."	A 093		

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A 093	Continued From page 43 3. On at 8:00 a.m., the hot food breakfast cart was delivered to the memory care unit by kitchen staff. The first beverage was served at 8:25 a.m. On at 8:25 a.m., the Dining Director stated breakfast starts at 8:00 a.m. and all food items are temperature checked on the steam table prior to serving the meals. Review of the temperature log completed for the breakfast meal on , documented temperatures for oatmeal 201 degrees Fahrenheit (F), eggs 180 degrees F, meat/sausage 175 degrees F. On at 8:43 a.m., the Dining Director stated the cart used for serving the meals to the memory care dining room is a service cart and not an electric warming cart, so it does not keep the meals hot or warm. The Dining Director stated the staff are to serve the meals when he delivers the meal cart at 8:00 a.m. to the memory care dining room. On at 8:47 the last breakfast tray was served. The Dining Director checked the temperature of the food on the last tray. The scrambled eggs were being served at 86.7 degrees F. The Dining Director stated he can't give an answer as to why the cart sat in the dining room for over 40 minutes and was served so late. He said he is required to get the meal cart to the dining room by 8:00 a.m. and expects the staff to serve the meals immediately. The Dining Director confirmed the breakfast meals served after 8:40 a.m. were . On at 9:06 a.m., the Executive Director stated once the service cart comes to the MC dining room the expectation is for the care	A 093		

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A 093	Continued From page 44 partners to serve the meals. She said the staff should not be waiting over 40 minutes before serving the meals. The Executive Director confirmed the cart is a service cart and if meals sit in the cart for over 40 minutes before serving, the meals served would be . 4. On at 8:00 a.m., 28 residents were observed in the dining room. The first beverage was served at 8:25 a.m. Coffee was served in Styrofoam cups to 4 residents. On at 8:25 a.m. Staff H said memory care residents are not served coffee in coffee cups or mugs. On at 11:53 a.m. water was served to residents in Styrofoam cups. On at 12:13 p.m., the lunch cart was delivered to the memory care unit. The first tray was passed at 12:14 p.m. Only 5 residents out of 34 had forks (1 was a plastic fork). The ED came to memory care dining and verified residents were eating with their ; no forks were provided. The ED obtained plastic forks for the residents because the kitchen did not have any regular silverware to provide. The ED said the residents should have regular silverware and mugs, not Styrofoam or plastic silverware. Class III	A 093		
AE203 SS=D	59A-36.021(3) FAC ECC - Staffing Requirements (3) STAFFING REQUIREMENTS. The following staffing requirements apply for extended congregate care services:	AE203		

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AE203	Continued From page 45	AE203		

(a) Supervision by an administrator who has a minimum of two years of managerial, nursing, social work, therapeutic recreation, or counseling experience in a residential, long-term care, or acute care setting or agency serving elderly or persons. If an administrator appoints a manager as the supervisor of an extended congregate care facility, both the administrator and manager must satisfy the requirements of subsection 59A-36.010(1), F.A.C.
1. A baccalaureate degree may be substituted for one year of the required experience.
2. A nursing home administrator licensed under chapter 468, F.S., is qualified under this paragraph.
(b) Provide staff or contract the services of a nurse who must be available to provide nursing services, participate in the development of resident service plans, and perform monthly nursing assessments for extended congregate care residents.
(c) Provide enough qualified staff to meet the needs of extended congregate care residents in accordance with rule 59A-36.010, F.A.C., and to provide the services established in each resident's service plan.
(d) Ensure that adequate staff is awake during all hours to meet the scheduled and unscheduled needs of residents.
(e) Immediately provide additional or appropriately qualified staff, when the agency determines that service plans are not being followed or that residents' needs are not being met because insufficient staffing, in accordance with the staffing standards established in rule 59A-36.010, F.A.C.
(f) Ensure and document that staff receive extended congregate care training as required in rule 59A-36.011, F.A.C.

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AE203	Continued From page 46 This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the Extended Congregate Care (ECC) program was supervised by a trained, qualified staff person. The findings included: The ECC Oversight Registered Nurse (RN) Services contract was signed on [redacted] to "complete monthly Extended Congregate Care (ECC) assessments and nursing reviews of service plans and all other documentation regarding ECC services for residents currently on or needing further evaluation of such services. A 60-day notice of intent to cancel the contract is required by both Naples Green Village and RN." The Naples Green Village Residency Agreement Exhibit F, "ECC PROCEDURE" noted the administrator will be responsible for monitoring the residents needs and for ensuring that those are met until the agreed upon Personal Service Plan is in effect. On [redacted] at 10:04 a.m., the Executive Director (ED) verified 14 residents were referred to a third-party provider without being offered facility nursing services. The ED confirmed the resident contract states nursing services are available under the ECC program. The ED said a contract was signed with an RN as ECC Supervisor. The ED said the ECC service was not implemented so the facility did not obtain an employment application for the ECC designated nurse and did not submit the nurse for background screening. She said no on boarding or training was done as the nurse was [redacted] and then not needed. The ED said residents receive home health	AE203		

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AE203	Continued From page 47 through a preferred partner who's caregivers are not part of the facility staff. The ED said when residents are admitted they are not offered ECC services although the contract includes ECC services. ECC service is not a separate charge. The resident fee is all inclusive. On [redacted] at 1:15 p.m., the Executive Director verified the designated ECC nurse did not have a background check completed and was not added to the employee roster. On [redacted] at 1:30 p.m., the Marketing Director said she completes the initial contracts with residents and the responsible party. She said she reviews the ECC license and explained it helps the facility to be able to provide a higher level of care to each resident based on their needs. The Marketing Director said we tell the new resident we always partner with home health. She said she tells the resident we can assist or administer [redacted] but the third party providers partner with us to care for everyone. Class III	AE203		
AE210 SS=D	59A-36.011(8) FAC ECC - Training (8) EXTENDED CONGREGATE CARE (ECC) TRAINING. (a) The administrator and ECC supervisor, if different from the administrator, must complete core training and 4 hours of initial training in extended congregate care prior to the facility receiving its ECC license or within 3 months of beginning employment in a currently licensed ECC facility as an administrator or ECC supervisor. Successful completion of the assisted living facility core training shall be a prerequisite	AE210		

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AE210	Continued From page 48	AE210		

for this training. ECC supervisors who attended the assisted living facility core training prior to [illegible], shall not be required to take the assisted living facility core training competency test.
(b) The administrator and the ECC supervisor, if different from the administrator, must complete a minimum of 4 hours of continuing education every two years in topics relating to the physical, [illegible], or social needs of frail elderly and [illegible] persons, or persons with [illegible] or related [illegible].
(c) All direct care staff providing care to residents in an ECC program must complete at least 2 hours of in-service training, provided by the facility administrator or ECC supervisor, within 6 months of beginning employment in the facility. The training must address ECC concepts and requirements, including statutory and rule requirements, and the delivery of personal care and supportive services in an ECC facility.

This Statute or Rule is not met as evidenced by:
Based on record reviewed and interview facility failed to ensure 4 (Staff D, E, F, Administrator) had at least 2 hours of in-service of ECC training within 6 months of hire and the ECC Supervisor/Administrator completed 4 hours of ECC training within 3 months of hire for Extended Congregate Care (ECC), [illegible] ECC concepts and requirements.

Findings included:

Record review found staff D was hired on [illegible] as a Resident Aide/Care Partner. Further review found no evidence of completion of 2 hours of ECC training.

Record review found Staff E was hired on

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AE210	Continued From page 49 as a Care Partner. Further review found no evidence of completion of 2 hours of ECC training. Record review found Staff F was hired on as a Care Partner. Further review found no evidence of completion of 2 hours of ECC training. Record review of the Administrator's file revealed a hire date of . Further review found evidence of certificate of completion on for 1 hour of FL Congregate Care part 1, and 1 hour of FL Congregate Care Part 2. Regulations require 4 hours of ECC training within 3 months of hire. There was no further evidence of completion of ECC training in the Administrators' record. On at 1:27 p.m., the Business Office Manager confirmed the lack of ECC training. Class III	AE210		

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CZ814 SS=C	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the , , are enrolled in the national retained print notification program at the Federal Bureau of Investigation: 1. A person with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. 2. Effective , , , or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity. (c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse. 1. Before , , , initial status and any changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person ' s status has been made. 2. Effective , , , initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person ' s status has been made.	CZ814		

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CZ814	Continued From page 1 (d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic , submission to the Department of Law Enforcement. The registration must include the person ' s full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure 2 (Staff E, and F) of 5 employees reviewed, had the Level 2 background screening employment status updated within 10 days on the Agency for Healthcare of administration (AHCA) Background screening clearinghouse website pursuant to chapter 435. This had the potential for staff with disqualifying offenses to have access to adults. The findings Included: Record Review of Staff E's file revealed a hire date of as a Care Partner. Review of the Agency' clearing house employee roster revealed Staff D was added on the clearing house roster on , 65 days after hire. Record Review of Staff F's file revealed a hire date of as a Care Partner. Review of the Agency' clearing house employee roster revealed	CZ814		

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CZ814	Continued From page 2 Staff E was added on the clearing house roster on , 42 days after hire. On at 1:27 p.m., the Business Office Manger confirmed the findings. Unclassified	CZ814		