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
	AL11910126	A. BUILDING: _____ B. WING _____	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ821	59A-35.110( ) FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal.	CZ821		

AHCA Form 3020-0001

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

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

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

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CZ821	Continued From page 3 to $50 per day late not to exceed $500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on facility's documentation, resident record review, and interview, the facility failed to submit adverse incident reports timely electronically to the agency for 2 of 5 sampled residents, (#2 & #3) as required within the required timeframes. Findings: 1. On (three days late), an adverse incident was submitted electronically to the agency for an emergency response event that occurred on for resident #2 who was found unresponsive by Medication Technician (Med Tech) C when she entered resident #2's room to assist with morning medications and remind her of breakfast. Furthermore, Med Tech C immediately notified Licensed Practical Nurse (LPN) B who entered resident #2's room, observing that resident #2 was purple in color and to touch. LPN B immediately called 911. First responders arrived at the facility at 8:57 AM, and called time of at 9 AM. Resident #2's record review revealed an admission date of . The 1823 Health Assessment dated listed medical history of , gait difficulty at times,	CZ821		

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CZ821	Continued From page 4 right side, Dyslipidemia, , and atrophy. She needed assistance in activities of daily living (ADLs) with bathing, grooming and toileting. She was independent with ambulation, eating, and transferring and needed assistance with self-administration of medications. The result was ( ) was not administered by a qualified staff to resident #2 (full code) who did not have a ( ) as required on . 2. On (two days late), an adverse incident was submitted electronically to the agency for an emergency response event that occurred on , for resident #3 who was observed by the Memory Care Manager (Nurse D) unresponsive in the shower. Resident #3 was found with the water running in the shower, lying on his side with his up on the shower step. Resident #3 had coming from his and was not breathing. First responders were called, and the ( ) was retrieved. First responders arrived while pads were applied, and they took over the resident #3's care. Resident #3 was pronounced by the first responders. Resident #3's physician and family were notified and handled all funeral arrangements with the funeral home. Prior to this incident Med Tech E had seen resident #3 at approximately 8:30 AM on (same day), when his medications were given to him. At that time resident #3 was alert/oriented and had no complaints. Resident #3 did not receive any -on assistance with his activities of daily living (ADLs).	CZ821		

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CZ821	Continued From page 5 Resident #3's record review revealed admission date of [redacted]. He [redacted] three days after admission into the facility. The 1823 Health Assessment dated [redacted] listed medical history of [redacted], hematuria, retention, moderate protein calorie [redacted], [redacted], [redacted], and [redacted] communication [redacted]. He was independent with ambulation, [redacted], eating, grooming, toileting, and transferring. He required supervision with bathing in ADLs and needed assistance with self-administration of medications. The facility did start to apply [redacted] correctly to resident #3 when the first responders arrived at the facility. (Photographic Evidence Obtained) On [redacted] at 3:30 PM, an interview with the Administrator confirmed both adverse incident reports were not submitted to the agency within the required timeframe. Unclassified	CZ821		
A 000	Initial Comments Complaint Investigations #2024003026, #2024003725 were conducted at Grand Villa of Altamonte Springs Assisted Living Facility & Memory Care on [redacted] & [redacted]. The facility had deficiencies at the time of the investigation survey visit.	A 000		

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A 030	Continued From page 6	A 030		
A 030 SS=J	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 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	A 030		

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A 030	Continued From page 7 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 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	A 030		

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A 030	Continued From page 8 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 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	A 030		

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A 030	Continued From page 9 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 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.	A 030		

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A 030	Continued From page 10 (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 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.	A 030		

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A 030	Continued From page 11 429.27 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 management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on facility documentation, resident record review, personnel record review, and interviews, the facility failed to honor rights for Advance Directives when , , ( ) was not performed on 1 of 5 sampled residents (#2), who was identified as a full code and did not have a ( ) during an emergency event that resulted in . Findings: The facility reported an emergency response event to the agency on at 8:51 AM. Resident #2 was found unresponsive by Medication Technician (Med Tech) C when she	A 030		

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A 030	Continued From page 12	A 030		

entered resident #2's room to assist with morning medications and remind her of breakfast. Med Tech C immediately notified nurse B who entered resident #2's room and observed resident #2 was purple in color and to touch. Licensed Practical Nurse (LPN) B immediately called 911. The first responders arrived at the facility at 8:57 AM and called time of at 9 AM.

On at 2:14 PM, a report was received from the Seminole County Fire Department, which documented the dispatcher notified station #11 of an emergency at the facility and they responded at 8:54 AM for a . The unit arrived at the ALF (Assisted Living Facility) at 8:57 AM and found a female resident down on the bed, unresponsive. Her skin was and dry with , fixed and dilated. She was pulseless, not breathing, and had no obvious signs of or , including and lividity. At 9 AM, she had no vital signs but a code was not called.

There was no documented evidence that LPN B and/or Med Tech C attempted to administer to resident #2 before first responders arrived at the facility.

Resident #2's record review revealed an admission date of . The 1823 Health Assessment dated listed medical history of , gait difficulty at times, right side, , dyslipidemia, , and atrophy. She needed assistance in activities of daily living (ADLs) with bathing, , grooming and toileting. She was independent with ambulation, eating, and transferring. Resident #2 also needed assistance with self-administration of medications.

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A 030	Continued From page 13 A facility note dated at 10:30 AM, by LPN B documented Med Tech C reached out to LPN B after having gone to give AM medications to resident #2 and stated that resident #2 was unresponsive. LPN B documented he went into resident #2's room immediately to check on her. Resident #2 was purple and . . . LPN B immediately called 911 and they arrived 3 minutes later. First responders called time of . . . . at 9 AM. LPN B documented he reached out to both the Power of Attorney and the resident's sister to inform them resident #2 had , . . On at 8:05 AM, LPN B interrupted a conversation the Administrator and the surveyor were having by asking the Administrator, "I am here, do you want me to work?" The Administrator answered, "Give me a few minutes and I will speak to you." LPN B was observed wearing the facility's uniform (facility's logo purple shirt). On . . . . . at 9 AM, in an interview with the ALF Manager on Duty, she confirmed she only submitted the emergency event to the agency (Agency for Health Care Administration). On at 10:10 AM, during an interview with Med Tech C about the incident with resident #2 on , she stated she did not speak English well and requested the questions be asked slowly. Med Tech C explained around 8:30 AM on . . . . . , she went to give resident #2 her morning medications and tell her it was time for breakfast. When she saw resident #2 not moving or not responding, she immediately called for LPN B. Med Tech C stated the only thing she or LPN B did was call 911 and confirmed . . was	A 030		

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	AL11910126	A. BUILDING: _____ B. WING _____	03/27/2024

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GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

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A 030	Continued From page 14 not performed. On . . . . . at 10:30 AM, LPN B was contacted regarding the incident with resident #2 on . . . . LPN B declined to be interviewed and stated he was not currently working and walked away. He was observed with his backpack leaving the facility. On at 12:10 PM, a telephone interview with nurse B was attempted. There was no answer and no call after a voicemail message was left. On . . . . . at 12:13 PM, an interview was conducted with the Administrator regarding the incident with resident #2 on . . . . The administrator stated LPN B was suspended immediately on . . . . . pending investigation resulting in permanent termination that day, ... , because LPN B did not follow the facility's policies. The administrator asked LPN B during the internal investigation, why he didn't immediately perform on resident #2. LPN B answered when he touched resident #2's forehead she was and stiff, and it was his opinion she had already , ... The Administrator stated he was very disappointed with LPN B because he knew better and was a licensed nurse that should have known what to do in an emergency. The Administrator explained LPN B should have followed the facility's policies and procedures on Emergency Response for and Advanced Directives, revised . The Administrator provided a copy of the facility's policies/procedures for Emergency Response for and Advance Directives, revised on , which noted the community honors resident's rights to refuse medical treatment through	A 030		

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A 030	Continued From page 15 Advance Directives and in the event of emergency. Furthermore, the policies and procedures detailed what staff should do upon discovery or witnessing a resident in distress to include: 4. a. Request a second staff member to bring the or binder. b. Perform and/or use First Aid and utilize as necessary. A review of LPN B's personnel record revealed his hire date to be . Continued interview with administrator on at 12:13 PM, revealed he was suspended immediately pending investigation on , as he did not perform on resident #2 that day. Afterwards, the facility conducted an internal investigation and LPN B's employment was terminated on . The personnel record further showed LPN B completed the facility specific 1-hour update on and training on and the certification indicated he was qualified to begin and administer the Automated External Defibrillator ( ) pads to resident #2 on but did not do so. However, review of LPN B's nursing license, found in his personnel file, indicated it had expired last year on and review of the Level 2 Background Screening eligibility form also documented an expiration date of for his nursing license. Although LPN B's personnel did not have the current license information, on at 11:42 AM, a telephone interview with a representative for the Department of Health (DOH) confirmed that LPN B completed his renewal for LPN nurse	A 030		

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A 030	Continued From page 16 license on . . . . . confirming a new expiration date of , indicating Nurse B did have an active LPN license at the time of the incident. Review of Med Tech C's personnel record revealed a hire date of . Her certification expired on . . . . . (last year). She had completed her facility specific 1-hour and . . . . training, along with 1 hour resident rights training, and 1 hour reporting adverse incidents on . . . . . On . . . . . at 11:38 AM, the Administrator stated Med Tech C told him that her certification had expired, and she told LPN B to assist with on resident #2. Resident #2's rights for advanced directives were not honored when facility staff failed to perform upon finding her unresponsive, purple, and . . . on . . . . . by LPN B and Med Tech C. Resident #2 did not have a and was a full code which meant was to be administered and/or pads applied until first responders arrived to take over. Class I	A 030		
A 077 SS=D	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120	A 077		

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A 077	Continued From page 17 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least [illegible]; 2. If employed on or after [illegible], have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after	A 077		

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A 077	Continued From page 18 becoming employed as a facility administrator. Administrators who attended core training prior to [redacted], are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the [redacted] of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile [redacted] of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities.	A 077		

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A 077	Continued From page 19 (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No =Ref-09393. This Statute or Rule is not met as evidenced by: Based on observation, facility's documentation, and interview, the facility failed to ensure the Administrator who had the responsibility of the day to day operations, specifically honored residents rights to provide ( ) and follow facility ( ) policies and procedures as required for 1 of 5 sampled residents, (#2); and failed to ensure nurse licenses were active with current documentation in the personnel as required for 1 of 6 sampled staff, (Licensed Practical Nurse B) .	A 077		

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A 077	Continued From page 20 Findings: 1.The facility reported an emergency response event to the agency on at 8:51 AM, resident #2 was found unresponsive by Medication Technician (Med Tech) C when she entered resident #2's room to assist with morning medications and remind her of breakfast. Furthermore, Med Tech C immediately notified Licensed Practical Nurse (LPN) B who entered resident #2's room and observed the resident was purple in color and to touch. LPN B immediately called 911. First responders arrived at the facility at 8:57 AM and called time of at 9 AM. On at 2:14 PM, a report received from the Seminole County Fire Department documented the dispatcher notified station #11 who responded at 8:54 AM for a . The unit arrived at the Assisted Living Facility at 8:57 AM and found a female resident down on the bed, and unresponsive. Her skin was and dry, fixed and dilated. She was not breathing, was pulseless, with no obvious signs of including and lividity or noted. At 9 AM resident #2 had no vital signs. No code was called. There was no documented evidence LPN B and/or Med Tech C attempted to administer to resident #2 before first responders arrived to the facility. A facility note dated at 10:30 AM, documented by LPN B read, Med Tech C reached out to this nurse after having gone to give AM medications to resident #2 and stated that resident #2 was unresponsive. LPN B went into resident #2's room immediately to check on the	A 077		

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A 077	Continued From page 21 resident. Resident #2 was purple and . . . . LPN B immediately called 911 who arrived 3 minutes later. First responders called time of . . . . at 9 AM. LPN B reached out to both Power of Attorney and sister to inform them resident #2 had , ... On at 8:05 AM, LPN B interrupted a conversation the Administrator and surveyor were having by asking the Administrator, "I am here, do you want me to work?" The Administrator answered, "Give me a few minutes and I will speak to you." LPN B was observed wearing the facility's uniform (facility's logo purple shirt). On at 10:30 AM, an interview was attempted with LPN B regarding the incident with resident #2 on . He declined the interview and stated he was not working and walked away. He was observed with his backpack leaving the facility. On . . . . . at 12:10 PM, a telephone interview with LPN B was attempted, but there was no answer and no call . . . . was received after a voicemail message was left. On at 12:13 PM, in an interview with the Administrator regarding the incident with resident #2 on , he stated LPN B was immediately suspended on . . . . . , pending investigation which resulted in his employment being permanently terminated . . . . . . The Administrator explained LPN B did not follow the facility's policies. Furthermore, the Administrator stated LPN B had explained he touched resident #2's forehead and she was . . and stiff which in his opinion meant she was already . The Administrator continued, he was very disappointed with LPN B because he knew better	A 077		

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A 077	Continued From page 22 as he was a licensed nurse so he should have known what to do in this emergency and followed the facility's policies and procedures on Emergency Response for and Advanced Directives, revised . The Administrator provided a copy of the facility's policies/procedures for Emergency Response for and Advance Directives, revised which stated the community honored resident's rights to refuse medical treatment through Advance Directives and in the event of emergency. Furthermore, the policies and procedures detailed what staff should do upon discovery or witnessing a resident in distress: a. Request a second staff member to bring the ( ) or binder. b. Perform and/or use First Aid and utilize as necessary. LPN B's certification was current and expired on which he was qualified to give or administer the pads to resident #2 on but chose not to do so. Review of LPN B's personnel filed revealed a copy of license# PN5242859 which expired . Also, the Level 2 Background Screening eligibility form documented the expiration date as for his license. He completed the facility specific 1-hour update on and training on . A review of Med Tech C's personnel record review revealed hire date . Her certification expired on . There was no documented evidence to show was begun on resident #2 by LPN B and/or	A 077		

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A 077	Continued From page 23 by Med Tech C as required when resident #2 was unresponsive, purple, and on . Resident #2 did not have an and was a full code for which should be administered and/or pads applied until first responders arrived to take over. Therefore, the facility did not honor resident's rights for . 2. A review on of LPN B's personnel record revealed the copy of LPN license# PN5242859 expired (last year), and the Level 2 Background Screening (BGS) eligibility form dated that nurse B's license expired on on the facility's documentation. On at 10:30 AM, an interview with the Administrator to request the facility's policy/procedure for verifying nurse licenses and Certified Nursing Assistant (CNA) licenses employed at the facility were current and he provided the policy/procedure below. A Required Employee Documentation policy and procedures, update version , was provided and documented the policy of the company to maintain certain documents relative to each employee. These requirements ensure all state and federal licensing guidelines are maintained. Procedure: A. A required employee documentation grid (per 66) is maintained detailing documentation requirements for all employees both at hire and ongoing. The grid is updated as needed. B. The Executive Director and supervisors should review employment records regularly to ensure all documentation is maintained as	A 077		

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A 077	Continued From page 24 required in the appropriate location. C. Employees not in compliance with the Required Employee Documentation grid and have not provided the documentation as requested should be removed from the work schedule until the documents are received. Employees removed from the schedule due to incomplete documentation should be provided notice in writing. Employees remaining off the schedule for more than 30 days due to incomplete documentation will be separated from employment as voluntary resignation after consulting with the Regional Director of Operations. In addition, the Administrator, confirmed he did not know LPN B's license expired on . . . . . . On . . . . . at 11:10 AM, in an interview with the Business Office Manager (BOM) to request the facility's system or facility's policy that was in place to ensure all nurses' licenses and CNA licenses were up to date and current. The BOM explained every couple of months she reviewed her Excel spreadsheet to see what licenses and trainings were due for renewal. Today, the BOM reviewed LPN B's license in the personnel file and stated she did not know LPN B's license had expired on . The BOM confirmed she did know LPN B's license expired. The BOM apologized for missing this error and said they will do better next time. The BOM provided an updated copy of LPN B's license with expiration date . . . . . printed from the Department of Health (DOH) website. In addition, the surveyor showed the BOM LPN B's license was expired on the Level 2 BGS eligibility form. The BOM reviewed her spreadsheet to ensure no other nurses or CNAs	A 077		

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A 077	Continued From page 25 licenses were expired and was able to provide appropriate documentation. On at 11:38 AM, the Administrator stated Med Tech C told him her certification had expired, and she told LPN B to assist with . On at 11:42 AM, a telephone interview with a representative for the DOH confirmed LPN B completed his renewal for LPN nurse license# PN5242859 on with new expiration date of . LPN B had an active LPN license. The Administrator's personnel record review revealed a hire date of . His Assisted Living Facility (ALF) CORE certification license #171242446 dated for completion on . He completed an ALF CORE training update of 13.75 hours on as well as the facility specific 1-hour and training update on , 1 hour resident rights training update on , and 1 hour emergency response and Adverse incident reporting training update on . The was no documented evidence the facility and the Administrator followed the facility's Required Employee Documentation policy and procedures, updated version , as required. Neither the Administrator nor the Business Office Manager were aware Staff B had an expired license in his personnel file until it was brought to their attention after personnel record review by the agency. (Photographic Evidence Obtained)	A 077		

Agency for Health Care Administration

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A 077	Continued From page 26 Class III	A 077		