

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/15/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

INN ASTON GARDENS AT THE COURTYARDS

**255 COURTYARDS BLVD
SUN CITY CENTER, FL 33573**

(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
CZ814	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		

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/15/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

INN ASTON GARDENS AT THE COURTYARDS

**255 COURTYARDS BLVD
SUN CITY CENTER, FL 33573**

(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
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 interview, the facility failed to maintain the employment status of employees within five business days from their dates of hire on the facility's background screening clearinghouse roster for six employees (Staff A, B, C, D, E, and F) of six sampled employees. Findings Included: A review of the facility's background screening clearinghouse employee roster, conducted on , revealed that Staff A, B, C, D, E, and F were not listed as current employees of the facility. A review of the facility's list of employees, conducted on , revealed that Staff A, B, C, D, E, and F were listed as current employees. Staff A was hired as a Medication Technician on . Staff B was hired as a	CZ814		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/15/2024
NAME OF PROVIDER OR SUPPLIER INN ASTON GARDENS AT THE COURTYARDS			STREET ADDRESS, CITY, STATE, ZIP CODE 255 COURTYARDS BLVD SUN CITY CENTER, FL 33573		
(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
CZ814	Continued From page 2 Care Manager on Staff C was hired as a Care Manager on Staff D was hired as a Care Manager on Staff E was hired as a Medication Technician on Staff F was hired as a Care Manager on A review of the facility's staffing schedule, conducted on, revealed that Staff A, B, C, D, E, and F had worked and were scheduled to work in the facility in During an interview with the Administrator and Business Office Manager, conducted on at 02:45pm, the Administrator and Business Office Manager agreed that the facility's background clearinghouse employee roster was not up to date and did not include Staff A, B, C, D, E, and F. Unclassified	CZ814			
CZ816	408.809(2) 435.05(2) 59A-35.090(2d-3b) Background Screening-Compliance Attestation 408.809 Background screening; prohibited offenses.- (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's to the Federal Bureau of Investigation for a national criminal history record check unless the	CZ816			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/15/2024
NAME OF PROVIDER OR SUPPLIER INN ASTON GARDENS AT THE COURTYARDS			STREET ADDRESS, CITY, STATE, ZIP CODE 255 COURTYARDS BLVD SUN CITY CENTER, FL 33573		
(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
CZ816	Continued From page 3 person's _____ are enrolled in the Federal Bureau of Investigation's national retained print _____ notification program. If the _____ of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit _____ electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the _____ to the Federal Bureau of Investigation for a national criminal history record check. The _____ shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print _____ notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person _____. The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that: (a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section; (b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and (c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms	CZ816			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/15/2024
NAME OF PROVIDER OR SUPPLIER INN ASTON GARDENS AT THE COURTYARDS			STREET ADDRESS, CITY, STATE, ZIP CODE 255 COURTYARDS BLVD SUN CITY CENTER, FL 33573		
(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
CZ816	Continued From page 4 provided by the agency. 435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers: (2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if _____ for any of the disqualifying offenses while employed by the employer. 59A-35.090 Background Screening. (2) Processing Screening Requests, Required Documents and Fees. (d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, _____, herein incorporated by reference, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-09106, and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Service/Background_Screening/Regulations_Forms.shtml. This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if _____ for any disqualifying offense. (e) An administrator or chief financial officer must be screened and qualified prior to _____ to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's	CZ816			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/15/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

INN ASTON GARDENS AT THE COURTYARDS

**255 COURTYARDS BLVD
SUN CITY CENTER, FL 33573**

(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
CZ816	Continued From page 5 secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the report and court disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to Section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with Section 435.06(3), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain a signed attestation of compliance with background screening requirements for two employees (Staff A and B) of six sampled employees. Findings Included: An employee record review for Staff A and B, conducted on , revealed that that Staff A and B's employee records did not contain a signed and dated attestation of compliance. Staff A was hired on . Staff B was hired on . During an interview with the Administrator and Business Office Manager, conducted on at 02:45pm, the Administrator and Business Office Manager agreed that Staff A and B's employee records did not contain a signed	CZ816		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/15/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

INN ASTON GARDENS AT THE COURTYARDS

**255 COURTYARDS BLVD
SUN CITY CENTER, FL 33573**

(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
CZ816	Continued From page 6 and dated attestation of compliance. Unclassified	CZ816		
CZ875 SS=D	430.5025(4 &) Training (4) Employees of covered providers must complete the following training for _____'s and related forms of _____: (a) Upon beginning employment, each employee must receive basic written information about interacting with persons who have _____'s or related forms of _____. (b) Within 30 days after beginning employment, each employee who provides personal care to or has regular contact with participants, patients, or residents must complete a 1-hour training program provided by the department. 1. The department shall provide training that is available online at no cost. The 1-hour training program shall contain information on understanding the basics about the most common forms of _____, how to identify the signs and symptoms of _____, and skills for communicating and interacting with persons with _____ 's _____ or related forms of _____. A record of the completion of the training program must be made available to the covered provider which identifies the training curricula, the name of the employee, and the date of completion. 2. A covered provider must maintain a record of the employee's completion of the training program and, upon written request of the employee, provide the employee with a copy of the record of completion consistent with the employer's written policies. 3. An employee who has completed the training	CZ875		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/15/2024
NAME OF PROVIDER OR SUPPLIER INN ASTON GARDENS AT THE COURTYARDS			STREET ADDRESS, CITY, STATE, ZIP CODE 255 COURTYARDS BLVD SUN CITY CENTER, FL 33573		
(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	
CZ875	Continued From page 7 required in this subsection is not required to repeat the program upon changing employment to a different covered provider. (c) Within 7 months after beginning employment for a home health agency, nurse registry, or companion or homemaker service provider, each employee who provides personal care must complete 2 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, and skills in working with families and caregivers. (d) Within 7 months after beginning employment for a nursing home, an assisted living facility, an adult family-care home, or an adult day care center, each employee who provides personal care must complete 3 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, skills in working with families and caregivers, group and individual activities, maintaining an appropriate environment, and ethical issues. (e) For an assisted living facility, adult family-care home, or adult day care center that advertises and provides, or is designated to provide, specialized care for persons with _____'s _____ or related forms of _____, in addition to the training specified in paragraphs (a) and (b), employees must receive the following training: 1. Within 3 months after beginning employment, each employee who provides personal care to or has regular contact with the residents or participants must complete the additional 3 hours of training as provided in paragraph (d). 2. Within 6 months after beginning employment, each employee who provides personal care must	CZ875			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/15/2024
NAME OF PROVIDER OR SUPPLIER INN ASTON GARDENS AT THE COURTYARDS			STREET ADDRESS, CITY, STATE, ZIP CODE 255 COURTYARDS BLVD SUN CITY CENTER, FL 33573		
(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
CZ875	Continued From page 8 complete an additional 4 hours of -specific training. Such training must include, but is not limited to, understanding and related forms of ..., the stages of ...'s ..., communication strategies, medical information, and stress management. 3. Thereafter, each employee who provides personal care must participate in at least 4 hours of continuing education each calendar year through contact hours, on-the-job training, or electronic learning ... For this subparagraph, the term "on-the-job training" means a form of direct coaching in which a facility administrator or his or her designee instructs an employee who provides personal care with guidance, support, or ...-on experience to help develop and refine the employee's skills for caring for a person with ...'s ... or a related form of ... The continuing education must cover at least one of the topics included in the ...-specific training in which the employee has not received previous training in the previous calendar year. The continuing education may be fulfilled and documented in a minimum of one quarter-hour increments through on-the-job training of the employee by a facility administrator or his or her designee or by an electronic learning ... chosen by the facility administrator. On-the-job training may not account for more than 2 hours of continuing education each calendar year. (f)1. An employee provided, assigned, or referred by a health care services pool must complete the training required in paragraph (c), paragraph (d), or paragraph (e) that is applicable to the covered provider and the position in which the employee will be working. The documentation verifying the completed training and continuing education of	CZ875			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/15/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

INN ASTON GARDENS AT THE COURTYARDS

**255 COURTYARDS BLVD
SUN CITY CENTER, FL 33573**

(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
CZ875	Continued From page 9 the employee, if applicable, must be provided to the covered provider upon request. 2. A health care services pool must verify and maintain documentation as required under s. 400.980(5) before providing, assigning, or referring an employee to a covered provider. (7) For a certified nursing assistant as defined in s. 464.201, training hours completed as required under this section may count toward the total hours of training required to maintain certification as a nursing assistant. (8) For a health care practitioner as defined in s. 456.001, training hours completed as required under this section may count toward the total hours of continuing education required by that practitioner's licensing board. (9) Each person employed, _____, or referred to provide services before _____, must complete the training required in this section before _____. Proof of completion of equivalent training completed before _____ shall substitute for the training required in subsection (4). Each person employed, _____, or referred to provide services on or after _____, may complete training using approved curriculum under paragraph (5)(d) until the effective date of the rules adopted by the department under subsection (6). This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that within thirty days of employment that employees completed a one-hour online training with the department regarding _____'s _____ and related forms of _____ for two employees (Staff A and B) of three sampled employees that provided personal care or had regular contact with residents.	CZ875		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/15/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

INN ASTON GARDENS AT THE COURTYARDS

**255 COURTYARDS BLVD
SUN CITY CENTER, FL 33573**

(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
CZ875	Continued From page 10 Findings included: An employee record review for Staff A and B, conducted on _____, revealed that Staff A and B's employee records did not contain evidence that the employees completed the one-hour online training with the department regarding _____'s _____ and related forms of _____ within thirty days of employment. Staff A was hired on _____ . Staff B was hired on _____ . During an interview with the Administrator, conducted on _____ at 02:45pm, the Administrator agreed that Staff A and B's employee records did not contain evidence that the employees completed the one-hour online training with the department regarding _____ and related forms of _____ within thirty days of employment. Class III	CZ875		
A 000	Initial Comments A biennial survey and a generator monitoring were conducted at Inn at Aston Gardens at The Courtyards on _____. Deficiencies were identified at the time of survey.	A 000		
A 010 SS=D	429.26() FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is	A 010		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/15/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

INN ASTON GARDENS AT THE COURTYARDS

**255 COURTYARDS BLVD
SUN CITY CENTER, FL 33573**

(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 010	Continued From page 11 responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing	A 010		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/15/2024
NAME OF PROVIDER OR SUPPLIER INN ASTON GARDENS AT THE COURTYARDS			STREET ADDRESS, CITY, STATE, ZIP CODE 255 COURTYARDS BLVD SUN CITY CENTER, FL 33573		
(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 010	Continued From page 12 supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/15/2024
NAME OF PROVIDER OR SUPPLIER INN ASTON GARDENS AT THE COURTYARDS			STREET ADDRESS, CITY, STATE, ZIP CODE 255 COURTYARDS BLVD SUN CITY CENTER, FL 33573		
(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 010	Continued From page 13 admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a _____ may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner. 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A _____, ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/15/2024
NAME OF PROVIDER OR SUPPLIER INN ASTON GARDENS AT THE COURTYARDS			STREET ADDRESS, CITY, STATE, ZIP CODE 255 COURTYARDS BLVD SUN CITY CENTER, FL 33573		
(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 010	Continued From page 14 the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain an updated health assessment when residents had a decline in condition that necessitated their admission into hospice services. Additionally, the facility failed to ensure residents admitted to hospice services had an interdisciplinary care plan that described the care and services provided by hospice and those provided by the facility and agreed upon by hospice, the facility, and the resident (or	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/15/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

INN ASTON GARDENS AT THE COURTYARDS

**255 COURTYARDS BLVD
SUN CITY CENTER, FL 33573**

(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 010	Continued From page 15 responsible party) for two Residents (#8 and #12) of two residents admitted to hospice services. Findings Included: A record review for Resident #8, conducted on _____, revealed that Resident #8 was admitted on _____. Resident #8 was admitted into hospice services on _____. Resident #8's health assessment form dated _____ did not note the type of assistance that Resident #8 required with transferring and _____. There were no _____ documented in Resident #8's record after _____. There was no order from Resident #8's primary care provider to discontinue _____. Resident #8's record did not include an interdisciplinary care plan that specified the care and services provided by hospice and those provided by the facility and agreed upon by hospice, the facility, and Resident #8 (or responsible party). A record review for Resident #12, conducted on _____, revealed that Resident #12 was admitted on _____. Resident #12 was admitted into hospice services on _____. Resident #12's health assessment form dated _____ did not note Resident #12's required nursing services of hospice on page one. There were no _____ documented in Resident #12's record after _____. There was no order from Resident #12's primary care provider to discontinue _____. Resident #12's interdisciplinary care plan dated _____ did not specify the care and services provided by hospice and those provided by the facility for _____ and _____ precautions. There was no evidence that the facility and Resident #12 (or responsible party) agreed with the interdisciplinary care plan.	A 010		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/15/2024
NAME OF PROVIDER OR SUPPLIER INN ASTON GARDENS AT THE COURTYARDS			STREET ADDRESS, CITY, STATE, ZIP CODE 255 COURTYARDS BLVD SUN CITY CENTER, FL 33573		
(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 010	Continued From page 16 During an interview with the Director of Nursing, conducted on _____ at 02:22pm, the Director of Nursing agreed that the facility failed to obtain updated health assessments when Residents #8 and #12 were admitted to hospice services. The Director of Nursing agreed that Resident #8's health assessment did not include the type of assistance that the resident required for transferring and _____. The Director of Nursing agreed that Resident #8's record did not include an interdisciplinary care plan. The Director of Nursing agreed that Resident #12's interdisciplinary care plan did not include the care and services provided by hospice and those provided by the facility for _____ and precautions. The Director of Nursing agreed that there was no evidence that the facility and Resident #12 agreed to the interdisciplinary care plan. The Director of Nursing stated that hospice obtained _____ for Residents #8 and agreed that the _____ were not documented in Resident #8 and #12 resident records. The Director of Nursing stated that Resident #8 and #12 primary care providers had not given the facility orders to discontinue obtaining their _____. Class III	A 010			
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	A 032			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/15/2024
NAME OF PROVIDER OR SUPPLIER INN ASTON GARDENS AT THE COURTYARDS			STREET ADDRESS, CITY, STATE, ZIP CODE 255 COURTYARDS BLVD SUN CITY CENTER, FL 33573		
(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 032	Continued From page 17 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 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,	A 032			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/15/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

INN ASTON GARDENS AT THE COURTYARDS

**255 COURTYARDS BLVD
SUN CITY CENTER, FL 33573**

(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 032	Continued From page 18 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 record review and interview, the facility failed to ensure that elopement drills included participation by all direct care staff and administration twice annually which include but not limited to five employees (Administrator and Staff B, C, D, and F) of fifty-five direct care staff. Findings Included: A review of the facility 's staff list, conducted on _____, revealed that there were fifty-five employees and administration employed at the facility. A review of the elopement drills, conducted on _____, revealed that from _____ through _____, the facility conducted eight elopement drills with employees. There were twenty-three employees that had not participated in an elopement drill which included the Administrator, Staff B, and Staff C. There were eighteen employees that had participated in one elopement drill which included Staff D and Staff	A 032		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/15/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

INN ASTON GARDENS AT THE COURTYARDS

**255 COURTYARDS BLVD
SUN CITY CENTER, FL 33573**

(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 032	Continued From page 19 F. There were no other elopement drills provided. During an interview with the Administrator, conducted on _____ at 02:40pm, the Administrator agreed that there was no evidence that the Administrator, Staff B, and Staff C had not participated in an elopement drill. The Administrator agreed that Staff D and Staff F had participated in one elopement drill. The Administrator stated that she was not aware that the facility had twenty-three employees that had not participated in an elopement drill. The Administrator was unable to provide any other elopement drills. Class III	A 032		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable _____. The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative _____ examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of _____ testing materials satisfies the annual _____ examination requirement. An	A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/15/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

INN ASTON GARDENS AT THE COURTYARDS

**255 COURTYARDS BLVD
SUN CITY CENTER, FL 33573**

(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 078	Continued From page 20 individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable, such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff.	A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/15/2024
NAME OF PROVIDER OR SUPPLIER INN ASTON GARDENS AT THE COURTYARDS			STREET ADDRESS, CITY, STATE, ZIP CODE 255 COURTYARDS BLVD SUN CITY CENTER, FL 33573		
(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 078	Continued From page 21 (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain evidence of a negative () examination annually and failed to obtain a one-time statement that the employee was free from communicable from a health care provider for one employee (Administrator) of one sampled employee. Findings Included: An employee record review for the Administrator, conducted on , revealed that the Administrator's employee record did not have evidence from a health care provider that the employee was free from annually as required or a one-time statement from a health care provider that the employee was free from communicable . The Administrator was hired on . During an interview with the Administrator and the Business Office Manager, conducted on at 02:45pm, the Administrator and the Business Office Manager agreed that the Administrator's employee record did not contain evidence of a negative examination or a one-time statement that the employee was free from communicable . Class III	A 078			
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011() FAC Training - Staff In-Service	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/15/2024
NAME OF PROVIDER OR SUPPLIER INN ASTON GARDENS AT THE COURTYARDS			STREET ADDRESS, CITY, STATE, ZIP CODE 255 COURTYARDS BLVD SUN CITY CENTER, FL 33573		
(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 22 429.52 (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. 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.	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/15/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

INN ASTON GARDENS AT THE COURTYARDS

**255 COURTYARDS BLVD
SUN CITY CENTER, FL 33573**

(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 23 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) 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	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/15/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

INN ASTON GARDENS AT THE COURTYARDS

**255 COURTYARDS BLVD
SUN CITY CENTER, FL 33573**

(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 24 must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident neglect, and The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 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	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/15/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

INN ASTON GARDENS AT THE COURTYARDS

**255 COURTYARDS BLVD
SUN CITY CENTER, FL 33573**

(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 25 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 provide direct care staff with training for activities of daily living and behavioral needs, elopement response, and nutrition and safe food handling within thirty days of employment. Furthermore, the facility failed to ensure that employee 2-hour pre-service orientation certificates were signed by the Administrator and the employees for two employees (Staff A and B) of two sampled employees. Findings Included: An employee record review for Staff A and B, conducted on _____, revealed that Staff A and B's employee records did not contain evidence that the employees obtained trainings regarding activities of daily living and behavioral needs, elopement response, and nutrition and safe food handling within thirty days of employment. Staff A and B's 2-hour pre-service orientation certificate was not signed by the Administrator and the employees. Staff A was hired on _____, Staff B was hired on _____. During an interview with the Administrator and Business Office Manager, conducted on _____ at 02:45pm, the Administrator and Business Office Manager agreed that Staff A and	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/15/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

INN ASTON GARDENS AT THE COURTYARDS

**255 COURTYARDS BLVD
SUN CITY CENTER, FL 33573**

(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 26 B's employee records did not include evidence that the employees obtained trainings for activities of daily living and behavioral needs, elopement response, and nutrition and safe food handling within thirty days of employment. The Administrator and the Business Office Manager agreed that Staff A and B's pre-service orientation certificates were not signed by the Administrator and the employees. Class III	A 081		
A 090 SS=D	59A-36.011(11) FAC Training - (11) TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that employees completed training for () for two employees (Staff A and B) of two sampled employees. Findings Included:	A 090		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/15/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

INN ASTON GARDENS AT THE COURTYARDS

**255 COURTYARDS BLVD
SUN CITY CENTER, FL 33573**

(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 090	Continued From page 27 An employee record review for Staff A and B, conducted on _____, revealed that Staff A and B's employee records did not contain evidence that the employees received training regarding _____ within thirty day of employment. Staff A was hired on _____. Staff B was hired on _____. During an interview with the Administrator and Business Office Manager, conducted on _____ at 02:45pm, the Administrator and the Business Office Manager agreed that Staff A and B's employee records did not contain evidence that the employees received training regarding _____ within thirty days of employment. Class III	A 090		
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.	A 093		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/15/2024
NAME OF PROVIDER OR SUPPLIER INN ASTON GARDENS AT THE COURTYARDS			STREET ADDRESS, CITY, STATE, ZIP CODE 255 COURTYARDS BLVD SUN CITY CENTER, FL 33573		
(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 28 (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 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.	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/15/2024
NAME OF PROVIDER OR SUPPLIER INN ASTON GARDENS AT THE COURTYARDS			STREET ADDRESS, CITY, STATE, ZIP CODE 255 COURTYARDS BLVD SUN CITY CENTER, FL 33573		
(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 29 (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. 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	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/15/2024
NAME OF PROVIDER OR SUPPLIER INN ASTON GARDENS AT THE COURTYARDS			STREET ADDRESS, CITY, STATE, ZIP CODE 255 COURTYARDS BLVD SUN CITY CENTER, FL 33573		
(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 30 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, record review, and interview, the facility failed to have enough food for three days in the event of an emergency for an in-house resident census of ninety-two residents. Additionally, the facility failed to post current menus in both the Memory Care and Assisted Living units. Furthermore, the facility failed to have annually approved menus by a Registered Dietician or other with the Registered Dietician original signature and the date of approval. Findings Included: During an observation of the emergency three-day food supply, conducted on at 10:30am, revealed that the facility had twenty-four cases of pre-made meals with twenty-five meals in each case which equaled 600 meals. At 01:00pm, there was no menu posted in the Memory Care Unit. At 01:30pm, the menu dated through posted outside of the Assisted Living Unit's main dining room. During an interview with the Food Service Manager, conducted on at 10:30am, the Food Service Manager agreed that the facility had 92 residents in-house and was required to have 828 meals available in the event of an emergency for three days. The Food Service Manager stated that he would order more meal	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/15/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

INN ASTON GARDENS AT THE COURTYARDS

**255 COURTYARDS BLVD
SUN CITY CENTER, FL 33573**

(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 31 kit cases. The Food Service Manager stated that the kitchen staff was working with week three of the menus for the lunch meal for Monday, A review of the lunch meal, conducted on _____ at 12:00pm, the lunch meal included Soup, Apple Waldorf Salad, Smoked Sausage, Chicken Cordon Bleu, Green Beans, and Red Velvet Cake. A review of the menu posted outside of the Assisted Living Units main dining room, conducted on _____, the menu dated _____ noted that today's meal was supposed to include Potato Soup, Cole Slaw, Chicken Marsala, Barbeque Meatballs, Spanish Rice, Spinach, and Chocolate Cake. The menu was not signed or dated by the Registered Dietician. A review of the week three menu signed and approved by the Registered Dietician on _____, conducted on _____, revealed that the lunch meal for Monday was to include Vegetable Soup or Salad, Red Beans with Sausage or Sliced Turkey _____, Rice, Mustard Greens, Corn Bread, and Apple Pie. During an interview with the Administrator, conducted on _____ at 02:50pm, the Administrator was unsure of which menu was supposed to be followed on Monday, _____. The Administrator agreed that there were menus not signed or dated in approval by the Registered Dietician. (photographic evidence obtained) Class III	A 093		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/15/2024
NAME OF PROVIDER OR SUPPLIER INN ASTON GARDENS AT THE COURTYARDS		STREET ADDRESS, CITY, STATE, ZIP CODE 255 COURTYARDS BLVD SUN CITY CENTER, FL 33573			
(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