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
	AL11967788	A. BUILDING: _____ B. WING _____	C 04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR OAKS AT LAKELAND HILLS	4141 LAKELAND HILLS BLVD LAKELAND, FL 33805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A biennial survey and a generator monitoring were conducted at Arbor Oaks at Lakeland Hills on . Deficiencies were identified at the time of survey.	A 000		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A 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.	A 032		

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A 032	Continued From page 1 The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case 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 all direct care staff and administration participated in the elopement drills twice annually for six employees (Staff A, B, C, D, F, and G) of six sampled employees. Findings Included: A review of elopement drills, conducted on	A 032		

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A 032	Continued From page 2 , revealed that Staff A, B, C, and F had not participated in any elopement drills that were performed on , , and . Staff D and G participated in one but not two elopement drills from through . There were no other elopement drills to review. The elopement drill performed on at 02:00pm, four administrative employees, one direct care employee, and three non-direct care employees participated in the elopement drill. The elopement drill performed on at 11:50am, two administrative employees and six non-direct care employees participated in the elopement drill. The elopement drill performed on at 02:50pm, three administrative employees, one direct care employee, and four non-direct care employees participated in the elopement drill. A review of the employee list, conducted on , revealed that there were 36 direct care employees and administration that were employed at the facility. Staff A was hired on as a Resident Aide. Staff B was hired on as a Resident Aide. Staff C was hired on as a certified Nurse Aide. Staff D was hired on as a certified Nurse Aide. Staff F was hired on as a Medication Technician. Staff G was hired on as a Medication Technician. During an interview with the Administrator, conducted on at 12:41pm, the Administrator agreed that all direct care staff and administration had not participated in elopement drills twice annually. The Administrator was unable to provide any other elopement drills. Class III	A 032		

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A 078	Continued From page 3	A 078		
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 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	A 078		

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A 078	Continued From page 4 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. (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 from a health care provider and failed to obtain a one-time statement that the employee was free from communicable from a health care provider for three employees (Staff A, B, and C) of three sampled employees. Findings Included: A record review for Staff A, conducted on	A 078		

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A 078	Continued From page 5 , revealed that Staff A did not have evidence from a health care provider that the employee was free from annually. Staff A did not have a one-time statement from a health care provider that the employee was free from communicable . Staff A was hired on . A record review for Staff B, conducted on , revealed that Staff B did not have evidence from a health care provider that the employee was free from annually. Staff B did not have a one-time statement from a health care provider that the employee was free from communicable . Staff B was hired on . A record review for Staff C, conducted on , revealed that Staff C did not have evidence from a health care provider that the employee was free communicable as required. Staff C was hired on . During an interview with the Administrator, conducted on at 11:50am, the Administrator agreed that Staff A and B's employee records did not have evidence from a health care provider that the employees were free from annually. The Administrator agreed that Staff A, B, and C, did not have a one-time statement from a health care provider that the employees were 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		

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A 081	Continued From page 6 429.52 (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. 59A-36.011	A 081		

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A 081	Continued From page 7 (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 must receive a minimum of 1 hour in-service	A 081		

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A 081	Continued From page 8 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 understanding and competency in the	A 081		

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A 081	Continued From page 9 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 control prior to direct care. Furthermore, the facility failed to provide direct staff with training regarding activities of daily living and behavioral needs, elopement response, nutrition and safe food handling, and resident rights recognizing and reporting , neglect, and , within thirty days of employment for three employees (Staff A, B and C) of three sampled employees. Findings Included: An employee record review for Staff A, conducted on , revealed that Staff A's employee record did not contain evidence that Staff A obtained training for control prior to direct care. Staff A's employee record did not contain evidence that Staff A obtained training regarding elopement response and nutrition and safe food handling within thirty days of employment. Staff A was hired on . An employee record review for Staff B, conducted on , revealed that Staff B's employee record did not contain evidence that Staff B obtained training for control prior to direct care. Staff B's employee record did not contain evidence that Staff B obtained training regarding activities of daily living and behavioral	A 081		

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A 081	Continued From page 10 needs, elopement response, nutrition and safe food handling, and resident rights recognizing and reporting [redacted], neglect, and [redacted] within thirty days of employment. Staff B was hired on [redacted]. An employee record review for Staff C, conducted on [redacted], revealed that Staff C's employee record did not contain evidence that Staff C obtained training for [redacted] control prior to direct care. Staff C's employee record did not contain evidence that Staff C obtained training regarding activities of daily living and behavioral needs, elopement response, nutrition and safe food handling, and resident rights recognizing and reporting [redacted], neglect, and [redacted] within thirty days of employment. Staff C was hired on [redacted]. During an interview with the Administrator and Business Office Manager, conducted on [redacted] at 1:30pm, the Administrator and Business Office Manager agreed that Staff A, B and C's employee records did not include evidence that the employees obtained trainings for [redacted] control prior to direct care. The Administrator and Business Office Manager agreed that A's employee record did not contain evidence that the employee received training regarding elopement response and nutrition and safe food handling within thirty days of employment. The Administrator and Business Office Manager agreed that Staff B and C's employee records did not contain evidence that the employee received training regarding activities of daily living and behavioral needs, elopement response, nutrition and safe food handling, and resident rights recognizing and reporting [redacted], neglect, and [redacted] within thirty days of employment.	A 081		

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A 081	Continued From page 11 Class III	A 081		
A 082 SS=D	59A-36.011(4) FAC Training - / (4) / (/). Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on and , including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that employees had the required one-time education course on / (/) for three employee (Staff A, B, and C) of three sampled employees. Findings Included: An employee record review for Staff A, conducted on , revealed that Staff A's employee record did not have evidence that the employe completed a one-time education course regarding / . Staff A was hired on . An employee record review for Staff B, conducted on , revealed that Staff B's employee record did not have evidence that the employe	A 082		

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A 082	Continued From page 12 completed a one-time education course regarding / . Staff B was hired on . An employee record review for Staff C, conducted on , revealed that Staff C's employee record did not have evidence that the employe completed a one-time education course regarding / . Staff C was hired on . During an interview with the Administrator, conducted on at 1:30pm, the Administrator agreed that Staff A, B, and C's employee records did not contain evidence that the employees completed a one-time education course regarding / . Class III	A 082		
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	A 090		

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A 090	Continued From page 13 failed to ensure that employees completed training for ( ) for three employees (Staff A, B and C) of three sampled employees. Findings Included: An employee record review for Staff A, B and C, conducted on , revealed that Staff A, B, and C's employee records did not contain evidence that the employees received training regarding within thirty days of employment. Staff A was hired on . Staff B was hired on . Staff C was hired on . During an interview with the Administrator and Business Office Manager, conducted on at 01:30pm, the Administrator and the Business Office Manager agreed that Staff A, B, and C'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	A 093		

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	AL11967788	A. BUILDING: _____ B. WING _____	C 04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR OAKS AT LAKELAND HILLS	4141 LAKELAND HILLS BLVD LAKELAND, FL 33805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 093	Continued From page 14 Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of 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	A 093		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 093	Continued From page 15 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. 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 [illegible] 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,	A 093		

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A 093	Continued From page 16 including adaptive equipment if needed by any resident, must be on . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have menus approved annually by a Registered Dietician. Findings Included: A review of the menu, conducted on , the menu was signed and approved by the Registered Dietician on . During an interview with the Dietary Director, conducted on at 11:11am, the Dietary Director agreed that the menus were approved by the Registered Dietician. The Dietary Director stated that the menus were updated every three years. During an interview with the Administrator, conducted on at 2:30, the Administrator agreed that the menus were approved by the Registered Dietician greater than a year ago. Class III	A 093		

Agency for Health Care Administration

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