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
	AL11965303	A. BUILDING: _____ B. WING _____	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN OAKS ASSISTED LIVING LLC	820 15 TH STREET N. SAINT PETERSBURG, FL 33705

(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 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response	A 032		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 032	Continued From page 1 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 elopement drills twice annually for four employees (Administrator and Staff A, B, and C) of four sampled employees. Findings Included: A review of elopement drills, conducted on [redacted], revealed that there were no elopement drills to review. An employee record review for the Administrator and Staff A, B, and C, conducted on [redacted], revealed that the Administrator and Staff A, B,	A 032		

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A 032	Continued From page 2 and C's employee records did not contain evidence that the employees participated in an elopement drill twice annually. The Administrator was hired on . Staff A was hired on . Staff B was hired on . Staff C was hired on . During an interview with the Administrator, conducted on at 12:00pm, 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 elopement drills. Class III	A 032		
A 034 SS=D	59A-36.007(9) ASSISTIVE DEVICES (9) ASSISTIVE DEVICES. Facilities are responsible for ensuring the safe usage of a resident's assistive devices. (a) The facility must have policies and procedures that include the requirements and methods for assessing the physical condition of assistive devices that may injure the resident and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device. (b) Documentation of each assistive device a resident uses must be included in the resident's record. (c) Direct care staff using assistive devices while rendering personal services to residents must know how to operate and utilize the equipment. (d) All assistive devices must be clean, in good repair, and free of hazards. (e) The facility must encourage and allow the resident to function with independence when using the assistive device.	A 034		

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A 034	Continued From page 3 This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to have a policy and procedures for wheelchair and walker assistive devices. Furthermore, the facility failed to have each assistive device documented in resident records for one Residents (#4) of one sampled resident that used a walker for ambulation. Findings Included: During an observation of Resident #4, conducted on at 09:35am, Resident #4 used a walker for ambulation. During a record review for Resident #4, conducted on , revealed that Resident #4 was admitted to the facility on . Resident #4's health assessment form did not note that the resident required the use of a walker for ambulation. There was nowhere found in Resident #4's record that the resident required the use of a walker for ambulation. During an attempt to review the facility's assistive devices policy and procedures, conducted on , revealed that there was no assistive devices policy and procedures to review. During an interview with the Administrator, conducted on at 12:19pm, the Administrator stated that the facility did not have an assistive devices policy and procedures in place. Class III	A 034		

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A 078	Continued From page 4	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 5 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 four employees (Administrator and Staff A, B, and C) of four sampled employees. Findings Included: An employee record review for the Administrator	A 078		

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A 078	Continued From page 6 and Staff A, B, and C, conducted on . . . . . , revealed that the Administrator and Staff A, B, and C's employee records did not contain evidence that the employees had a negative examination annually. The Administrator and Staff A, B, and C's employee records did not contain a one-time statement that the employees were free from communicable . . . . from a health care provider. The Administrator was hired on . Staff A was hired on . Staff B was hired on . . . . Staff C was hired on . . During an interview with the Administrator, conducted on . . . . . at 12:00pm, the Administrator agreed that her own employee record and Staff A, B, and C's employee records did not contain a negative examination annually. The Administrator agreed that her own employee record and Staff A, B, and C's employee record did not contain a one-time statement that the employees were free from communicable . . . . . from a health care provider. Class III	A 078		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by 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	A 081		

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A 081	Continued From page 7 employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee ' s personnel record. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously 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	A 081		

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A 081	Continued From page 8 administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in . . . . control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its . . . . control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne . . . . , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including 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	A 081		

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A 081	Continued From page 9 within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility	A 081		

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A 081	Continued From page 10 failed to provide direct care staff with in-service trainings for activities of daily living and behavioral needs and nutrition and safe food handling within thirty days of employment for one employee (Staff C) of three sampled employees. Findings Included: An employee record review for Staff C, conducted on , revealed that Staff C's employee record did not contain evidence that the employee completed trainings regarding activities of daily living and behavioral needs and nutrition and safe food handling within thirty days of employment. Staff C was hired on . During an interview with the Administrator, conducted on at 12:00pm, the Administrator agreed that Staff C's employee record did not contain evidence that the employee completed trainings regarding activities of daily living and behavioral needs and nutrition and safe food handling within thirty days of employment. 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	A 082		

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A 082	Continued From page 11 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 [redacted] for one employee (Staff A) of three sampled employees. Findings Included: A review of Staff A's employee record, conducted on [redacted], revealed that Staff A's employee record did not have evidence that the employee obtained a one-time statement education course on [redacted]. Staff A was hired on [redacted]. During an interview with the Administrator, conducted on [redacted] at 12:00pm, the Administrator agreed that there was no evidence in Staff A's employee record that the employee obtained a one-time education course on [redacted]. Class III	A 082		
A 083 SS=D	59A-36.011(5) FAC Training - First Aid and [redacted] (5) FIRST AID AND [redacted]). A staff member who has completed courses in First Aid and [redacted] and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able	A 083		

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A 083	Continued From page 12 to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that there was staff on each shift with training in first aid and ( ) for three employees (Staff A, B, and C) of four sampled employees. Findings Included: An employee record review for Staff A, B, and C, conducted on , revealed that there was no evidence in Staff A, B, and C's employee records that the employees obtained training in first aid and . Staff A was hired on . Staff B was hired on . Staff C was hired on . A review of the staff list, conducted on , revealed that there were four employees that were employed at the facility which included the Administrator and Staff A, B, and C. During an interview with the Administrator, conducted on at 12:00pm, the	A 083		

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A 083	Continued From page 13 Administrator agreed that Staff A, B, and C did not have first aid and training. Class III	A 083		
A 084 SS=D	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance.	A 084		

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WOODLAWN OAKS ASSISTED LIVING LLC	820 15 TH STREET N. SAINT PETERSBURG, FL 33705

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A 084	Continued From page 14 (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, , dosage forms, and , , , , and , , , , dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with syringes that are prefilled with the proper dosage by a pharmacist and , that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection; i. Assist with , , , , , , ; j. Use a , , , to perform , testing; k. Assist residents with , , and continuous positive airway pressure (CPAP)	A 084		

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A 084	Continued From page 15 devices, excluding the titration of the levels; l. Apply and remove stockings and hosiery; m. Placement and removal of bags, excluding the removal of the or manipulation of the site; and, n. Measurement of rate, temperature, and rate. (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by	A 084		

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A 084	Continued From page 16 rule the minimum requirements of this training This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed ensure that employees assisting residents with medications had the required six-hour training regarding assistance with self-administration of medications prior to assisting residents with their medications for one unlicensed Medication Technician (Staff C). Furthermore, the failed to ensure that employees assisting residents with medications had the required two-hours annual continuing education for assistance with self-administration of medications for two unlicensed Medication Technicians (Staff A and B) of three sampled Medication Technicians. Findings Included: An employee record review for Staff A, conducted on [redacted], revealed that Staff A obtained a six-hours training regarding assistance with self-administration of medications on [redacted]. Staff A's employee record did not contain evidence that the employee completed a two-hour continuing education for the years 2020, 2021, 2022, 2023, and 2024. Staff A was hired on [redacted]. An employee record review for Staff B, conducted on [redacted], revealed that Staff B obtained a six-hours training regarding assistance with self-administration of medications on [redacted]. Staff B's employee record did not contain evidence that Staff the employee completed a two-hour continuing education for the years 2021, 2022, 2023, and 2024. Staff B was hired on [redacted].	A 084		

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A 084	Continued From page 17 An employee record review for Staff C, conducted on . . . . . , revealed that Staff C obtained a two-hour continuing education regarding assistance with self-administration of medications on . There was no evidence that Staff C obtained a six-hour training regarding assistance with self-administration of medications prior to assisting residents with their medications. Staff C was hired on . During an interview with the Administrator, conducted on . . . . . at 12:00pm, the Administrator agreed that Staff A and B's employee records did not contain evidence that the employees completed as two-hour continuing education regarding assistance with self-administration of medications annually. The Administrator agreed that Staff C's employee record did not contain evidence that the employee completed a six-hour training regarding assistance with self-administration of medications prior to assisting residents with their medications. Class III	A 084		
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	A 093		

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A 093	Continued From page 18 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 week in advance for both regular and therapeutic	A 093		

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A 093	Continued From page 19 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 ⎵ 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	A 093		

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A 093	Continued From page 20 resident, must be on . . . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that menu substitutions were substituted with foods of comparable nutritional value. Findings Included: During an observation of the lunch meal, conducted on at 12:50pm, Staff A served residents meat pizza ordered from a local pizzeria. No vegetables were service with the lunch meal. A review of the menu, conducted on . . . . . , revealed that the lunch meal was supposed to include a salad. During an interview with Staff A, conducted on , Staff A stated that the employee had no time to prepare the lunch meal due to assisting with the survey process and providing care to residents. During an interview with the Administrator, conducted on at 01:15pm, the	A 093		

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A 093	Continued From page 21 Administrator agreed that the lunch meal did not include substitutions of comparable nutritional value. Class III	A 093		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside	A 152		

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A 152	Continued From page 22 commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . . . . . . This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide a safe, clean, decent, and homelike environment. Furthermore, the facility failed to maintain all existing mechanical and electrical systems in good working order (photographic evidence obtained). Findings Included: During observations, conducted on from 11:20am through 12:50pm, the dining room, there was one of three tubular light fixtures with no cover on it. There was one of three tubular light fixtures that had a cracked and broken cover. There were two chandeliers with five with five of seven light bulbs missing in each lighting fixture. There was no room or area that had comfortable seating for reading and engaging in socialization or other leisure time activities. The seating in the dining room were hard wood. There was one of two chairs by the kitchen area that was worn, torn, stained, and unsightly overstuffed chair. The backyard patio had a large collapsed canopy tent with a metal frame in the middle of the yard with the metal supports bent in many directions. There were seven coffee cans holding cigarette butts, three filthy wheelchairs, on filthy walker, and one tatter and worn recliner in various places in the yard. The hallway by , the lower part of the wall had a large area with	A 152		

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A 152	Continued From page 23 black scuffs and scratches and the small throw rug was visibly dirty and worn. 's entry door had black scuffs and scratches to the lower part of the doors. There was dust accumulation on outlet plugs and switch plates. During interviews with Residents #1, #2, #5, #6, #7, #8, and #10, conducted on at 11:20am, Residents #1, #2, #5, #6, #7, #8, and #10 stated that the facility did not have any comfortable seating. During an interview with Staff A, conducted on at 11:15am, Staff A stated that the Owner had no renovations planned for the inside of the building. During an interview with the Administrator, conducted on at 11:30am, the Administrator stated that the Owner lived in another country and was it was difficult to get ahold of the Owner. At 01:05pm, the Administrator stated that one resident would get the tent and move it and that when staff would put the tent , the resident would move it again. The Administrator stated that when the tent up where it was, the staff left it alone because the resident stopped moving the tent from one place to another. The Adminsitrator stated that all the furniture which include walkers and wheelchairs in the yard was junk and awaiting pickup from the junk removal company. The Adminstrator stated that the junk removal company came to the facility about every three to four months. The Adminsitrator was unable to state when the junk removal company last came to the facility or when they were scheduled to pick up at the facility. Class III	A 152		

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A 160 SS=D	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to Rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan,	A 160		

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A 160	Continued From page 25 with documentation of review and approval by the county emergency management agency, as described in Rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in Rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by Section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 59A-36.007, F.A.C. (j) All food service records required in Rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.435, F.S., and rule Chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions	A 160		

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A 160	Continued From page 26 and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.; (q) The facility's . . . . . prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.; (w) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have an up-to-date admission and discharge log listing the names of all residents that resided in the facility, their dates of admission, and the places they were admitted from. Furthermore, the facility failed to have a grievance procedure for receiving and responding to complaints and recommendations. Findings Included: A review of the facility's list of current in-house residents, conducted on , revealed that there were eleven residents residing in the facility. A review of the admission and discharge log,	A 160		

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	AL11965303	A. BUILDING: _____ B. WING _____	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN OAKS ASSISTED LIVING LLC	820 15 TH STREET N. SAINT PETERSBURG, FL 33705

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A 160	Continued From page 27 conducted on . . . . . , revealed that the admission and discharge log was not up-to-date. The admission and discharge log noted nineteen residents that resided in the facility. Residents #2 and #8 were not listed on the admission and discharge log. There were no discharge dates, places, and reasons of discharge for ten former residents (photographic evidence obtained). During an attempt to review the facility grievance log, conducted on . . . . . , revealed that there was no grievance log to review. During an interview with Staff A, conducted on . . . . . at 11:15am, Staff A stated that the admission and discharge provided was from the former facility/Owner/ Staff A stated that the current facility/Owner did not have an admission and discharge log. Staff A stated that the facility did not have a grievance log. During an interview with the Administrator, conducted on . . . . . at 11:30am, the Administrator stated that the facility did not have an admission and discharge log. At 12:19pm, the Administrator stated that the facility did not have a grievance policy and procedures in place. Class III	A 160		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. . , 3. Race, 4. Date of birth,	A 162		

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A 162	Continued From page 28 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if	A 162		

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A 162	Continued From page 29 such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an [redacted] recipient, a copy of the Department of Children and Families form Alternate Care Certification for [redacted] ([redacted]), CF-ES 1006, [redacted], which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No =Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the [redacted] of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is	A 162		

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A 162	Continued From page 30 a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's [redacted], DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain a [redacted]-to-[redacted] health assessment every three years for one Resident (#5). Furthermore, the facility failed to obtain and record [redacted] semi-annually for two Residents (#4 and #5) of two sampled residents. Findings Included: During an attempt to review [redacted] records for Residents #4 and #5, revealed that there was no [redacted] record to review.	A 162		

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A 162	Continued From page 31 A review of Resident #4's record, conducted on , revealed that there were no recorded in Resident #4's record since . Resident #4 was admitted to the facility on . . . . . Resident #4's health assessment dated noted that the resident was independent with all activities of daily living which had not been updated since the resident had a decline in condition and was admitted to hospice services. A review of Resident #5's record, conducted on . . . . . , revealed that there were no recorded in Resident #5's record since . . . . . Resident #5's health assessment dated was obtained greater than three years ago and noted that the resident required assistance with ambulation, bathing, grooming, and toileting. During an interview with Staff A, conducted on at 11:15am, Staff A stated that there was no log for recording for any of the residents. During an interview with the Administrator, conducted on at 11:30am, the Administrator agreed that Resident #5's health assessment had been performed greater than three years ago. The Administrator agreed that there were no documented in Resident #4 and #5's records in the years 2023 and 2024. Class III	A 162		
CZ816 SS=D	408.809(2) 435.05(2) 59A-35.090(2d-3b) Background Screening-Compliance Attestation 408.809 Background screening; prohibited	CZ816		

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CZ816	Continued From page 32 offenses.- (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's ... to the Federal Bureau of Investigation for a national criminal history record check unless the person's ... are enrolled in the Federal Bureau of Investigation's national retained print notification program. If the ... of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit ... electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the ... to the Federal Bureau of Investigation for a national criminal history record check. The ... shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person ... The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the Department of Financial Services for an applicant	CZ816		

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CZ816	Continued From page 33 for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that: (a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section; (b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and (c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency. 435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers: (2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if for any of the disqualifying offenses while employed by the employer. 59A-35.090 Background Screening. (2) Processing Screening Requests, Required Documents and Fees. (d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, , herein incorporated by reference, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-09106, and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Regulations_Forms.shtml. This form must be completed by the individual	CZ816		

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CZ816	Continued From page 34 and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if for any disqualifying offense. (e) An administrator or chief financial officer must be screened and qualified prior to to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the report and court disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to Section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with Section 435.06(3), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain a signed attestation of compliance with background screening requirements for two employees (Administrator and Staff A) of four sampled employees. Findings Included:	CZ816		

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CZ816	Continued From page 35 An employee record review for the Administrator and Staff A, conducted on [redacted], revealed that the Administrator and Staff A's employee records did not contain a signed attestation of compliance with background screening requirements. The Administrator was hired on [redacted]. The Administrator was hired on [redacted]. During an interview with the Administrator, conducted on [redacted] at 12:00pm, the Administrator agreed that her own employee record and Staff A's employee record did not contain a signed attestation of compliance with background screening requirements. Unclassified	CZ816		
CZ830 SS=D	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan.	CZ830		

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CZ830	Continued From page 36 (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for	CZ830		

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CZ830	Continued From page 37 the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to submit their comprehensive emergency management plan (CEMP) to the local emergency management agency annually for approval. Findings Included: During an attempt to review the approved CEMP, conducted on . . . . . , the Administrator provided an approval letter from the local emergency management agency from the previous facility/Owner in the year 2021. There	CZ830		

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CZ830	Continued From page 38 was no other CEMP approval letter provided. During an attempt to review the letter that the facility's CEMP had been submitted to the local emergency management office, conducted on , the letter of submission was not provided. During an interview with the Administrator, conducted on at 09:40am, the Administrator stated that she did not know if the CEMP had been submitted for approval. The Administrator was unable to provide a letter from the local emergency management office that the facility's CEMP had been submitted and/or approved. Class III	CZ830		
A 000	Initial Comments A biennial survey and a generator monitoring were conducted at Woodlawn Oaks assisted Living 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 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	A 010		

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A 010	Continued From page 39	A 010		

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 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

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	AL11965303	A. BUILDING: _____ B. WING _____	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN OAKS ASSISTED LIVING LLC	820 15 TH STREET N. SAINT PETERSBURG, FL 33705

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A 010	Continued From page 40 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 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	A 010		

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A 010	Continued From page 41 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 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	A 010		

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A 010	Continued From page 42 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 observation, record review, and interview, the facility failed to obtain an updated health assessment when one Resident (#4) of one sampled resident was admitted to hospice services. Findings Included: During an observation, conducted on at 09:35am, Resident #4 used a walker for ambulation. A record review for Resident #4, conducted on , revealed that Resident #4 was admitted to the facility on and into hospice services on . Resident #4's health assessment dated did not note	A 010		

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A 010	Continued From page 43 that the resident required the nursing services of hospice on page one. The health assessment form did not note Resident #4's physical limitations and use of a walker for ambulation. During an interview with the Administrator, conducted on [redacted] at 11:30am, the Administrator agreed that the facility did not obtain a [redacted]-to-[redacted] health assessment when Resident #4 was admitted to hospice services. The Administrator agreed that Resident #4's health assessment did not note the residents required nursing services of hospice and the resident's physical limitations. Class III	A 010		
A 026 SS=D	59A-36.007(2) FAC Resident Care - Social & Leisure Activities (2) SOCIAL AND LEISURE ACTIVITIES. Residents shall be encouraged to participate in social, recreational, educational and other activities within the facility and the community. (a) The facility must provide an ongoing activities program. The program must provide diversified individual and group activities in keeping with each resident's needs, abilities, and interests. (b) The facility must consult with the residents in selecting, planning, and scheduling activities. The facility must demonstrate residents' participation through one or more of the following methods: resident meetings, committees, a resident council, a monitored suggestion box, group discussions, questionnaires, or any other form of communication appropriate to the size of the facility. (c) Scheduled activities must be available at least 6 days a week for a total of not less than 12	A 026		

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A 026	Continued From page 44 hours per week. Watching television is not an activity for the purpose of meeting the 12 hours per week of scheduled activities unless the television program is a special one-time event of special interest to residents of the facility. A facility whose residents choose to attend day programs conducted at adult day care centers, senior centers, mental health centers, or other day programs may count those attendance hours towards the required 12 hours per week of scheduled activities. An activities calendar must be posted in common areas where residents normally congregate. (d) If residents assist in planning a special activity such as an outing, seasonal festivity, or an excursion, up to 3 hours may be counted toward the required activity time. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide an ongoing activities program that encouraged all residents to participate in social, recreational, education, and other activities within the facility. Findings Included: Observations throughout survey, conducted on from 09:15am through 01:30pm, revealed that there were no activities offered to any residents on an individual or group basis. During an attempt to review the weekly activities calendar, conducted on , revealed that there was no activity calendar posted or provided to review. During interviews with residents conducted on from 09:30am through 10:00am, residents stated that the facility did not have	A 026		

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A 026	Continued From page 45 activities. During an interview with Staff A, conducted on at 11:15am, Staff A stated that the residents don't participate in activities and that the facility did not have set activities. During an interview with the Administrator, conducted on at 11:30am, the Administrator agreed that there was no activity calendar posted or offered to residents. Class III	A 026		