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
	AL11965628	A. BUILDING: _____ B. WING _____	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL STARS ASSISTED LIVING, INC	1131 W LAKE BRANTLEY ROAD ALTAMONTE SPRINGS, FL 32714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the [illegible] are enrolled in the national retained print notification program at the Federal Bureau of Investigation: 1. A person with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. 2. Effective [illegible], or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity. (c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse. 1. Before [illegible], initial status and any changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person ' s status has been made. 2. Effective [illegible], initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person ' s status has been made.	CZ814		

AHCA Form 3020-0001

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

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CZ814	Continued From page 1 (d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic submission to the Department of Law Enforcement. The registration must include the person ' s full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review, interview and review of the background screening website, the facility failed to submit a request for screening for 1 of 3 sampled staff who had a break in service of more than 90 days from a position that required screening (caregiver C.) Findings: A review of caregiver C's personnel record revealed a hire date of . Review of the background screening website on at 11 am revealed a eligible background screening. It also revealed an employment end date of from her most recent position that required screening. Therefore, the facility should have submitted a request for a new screening. On at 11:16 am, the administrator said	CZ814		

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CZ814	Continued From page 2 she did not submit a new request because she did not know it was required. Unclassified	CZ814		
CZ821	59A-35.110( ) FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and available at:	CZ821		

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CZ821	Continued From page 3 https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers:	CZ821		

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CZ821	Continued From page 4 Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 6. For the purposes of this rule, the following applies for submitting adverse incident reports: a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day)	CZ821		

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CZ821	Continued From page 5 is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up to $50 per day late not to exceed $500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to electronically submit to the Agency for Health Care Administration (AHCA,) a preliminary report within 1 business day and a full report within 15 days of 1 of 11 sampled residents eloping from the facility (#1.) Findings: A review of resident #1's record revealed a facility admission date of [redacted]. The resident's medical history included [redacted] 's with behavioral disturbance, [redacted], and Major [redacted]. The resident ambulated independently without the aid of an assistive device and was considered a risk. He needed assistance with self-administration of medications. [redacted] and [redacted] health assessment	CZ821		

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CZ821	Continued From page 6 forms (form 1823) all indicated he was not an elopement risk. On at 12:41 pm, interview with resident's family member noted the resident always tried to leave the facility and verbalized wanting to take a bus to Egypt and wanting to obtain a passport to go see his family member there. The family said under the facility's current owner the resident left three times without staff knowing. The family member could only recall one event in when law enforcement found the resident approximately two miles from the facility. The family member continued to say he understood the facility previously installed an alarm on the front door and cameras. Further interview noted family member saying the resident had no money on him and the family member had the resident's ID. During interview on at 1:49 pm, with the administrator, she said there were two prior times the resident left the facility without staff knowing, but those incidents were not documented in the resident's record nor was a preliminary and a 15-day report submitted to AHCA as required. On at 1:59 pm, the administrator presented a text message from her to the resident's family member dated at 8:50 pm, where she indicated "he found the way to escape. We caught him in the front yard and got him in. Then he sat on the sofas at our porch. After that he has his dinner and that is all." The administrator said the events of the elopement happened sometime after lunch when she and the other staff realized the resident was not at the facility. A search was done inside and outside the facility, but he was not found. The administrator drove around the area. She	CZ821		

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CZ821	Continued From page 7 received a call from the police letting her know they found him in a neighborhood, exact location unknown. She said the resident left through the front door and although it was alarmed, she did not hear it. She said the resident did not sustain injuries while away from the facility. The administrator went on to say that in . . . sometime after lunch the resident packed personal items in a plastic bag. Afterwards he was sitting on the sofa and spoke with his family member. At some point he walked out the front door. No staff saw him leave and again the administrator stated she did not hear the front door alarm sound. At some point the staff did not see him so a search was conducted without success in locating him. Someone in the surrounding community called the police. The resident was located in a neighborhood approximately one mile from the facility. The administrator said the resident was tired and sitting in a shaded area on a curb when found. She said otherwise the resident was not injured. She said methods used to deter the resident from eloping were to put sports or religion on the television and give him food. She said the resident constantly packed his personal items and said he was going to leave. She said when the resident put his tennis shoes on staff knew he was going to try to leave. On at 2:36 pm, caregiver A said the resident packed personal belongings every day. She redirected him with food, television, his cell phone or called his family member to speak with him. Usually, the resident said he wanted to go to the bank, airport, to church or mentioned his family member. The caregiver said she regularly checked on him because of his tendency to want to leave. There were no specific times she did	CZ821		

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CZ821	Continued From page 8 that, but she frequently saw him walking around. The facility's undated elopement policy indicated that following an event where a resident eloped an incident report should be completed and submitted to AHCA. Unclassified	CZ821		
A 000	Initial Comments Complaint investigations #2024006606, #2024006646 and generator monitoring survey was conducted at All Stars Assisted Living on to . The facility had deficiencies at the time of the survey. Class I and Class II deficiencies were identified.	A 000		
A 025 SS=J	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the	A 025		

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A 025	Continued From page 9 appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide adequate	A 025		

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A 025	Continued From page 10 supervision when 1 of 11 sampled residents eloped three times from the facility, (#1.) Findings: A facility incident report indicated that on caregiver A last saw resident #1 at approximately 11:30 am when he went out to the porch and sat on a sofa. Approximately 5 minutes later, he came inside and went to his room. At 12:30 pm, caregiver A began serving lunch. She went to get the resident and could not find him. A search of inside and outside the facility did not locate the resident. The administrator was notified, and she called the resident's family and law enforcement. Nearby hospitals were called and visited, and the resident was not located. Law enforcement conducted a search with the use of police dogs, drones, and helicopters without success. A review of resident #1's record revealed a facility admission date of . The resident's medical history included 's with behavioral disturbance, , and Major , . The resident ambulated independently without the aid of an assistive device and was considered a risk. He needed assistance with self-administration of medications. On , and , completed health assessment forms (1823) all indicated he was not an elopement risk. A facility note indicated the resident spoke with his family member and was concerned about another family member. He thought the other family member was sick and wanted to go see them. He asked for a passport	A 025		

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A 025	Continued From page 11 to go to the airport. After lunch he forgot about it and stayed in his room. A 12 pm, a facility note indicated the resident had the idea to get out of the facility. To distract him, the administrator took the resident with her to buy groceries. There were no facility notes from 12 pm until the note dated documented below. On a facility note indicated the search continued to find the resident, when he could not be located at 12:30 p.m. when staff began serving lunch. The staff collaborated with the authorities and maintained communication with the family. A 5:30 pm, a facility note indicated the facility collaborated with the police department by providing information to the best of their ability. A review of the resident's Medication Observation Record (MOR) revealed he was prescribed the following medications: D 2,000-unit 1 tablet once daily for supplement. 50 milligrams (mg) 1 tablet three times daily for 0.5 mg half-tablet daily at noon for 5 mg 1 tablet twice daily for 0.5 mg 1 tablet twice daily for 10 mg 1 tablet twice daily for 3 mg 1 capsule twice daily for	A 025		

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A 025	Continued From page 12 The facility last gave the resident his medications on the morning of . On at 12:41 pm, the resident's family member said the resident always tried to leave the facility and verbalized wanting to go to Egypt. He verbalized wanting to take a bus to Egypt. He verbalized wanting to obtain a passport to go see his family member in Egypt. The family said under the facility's current owner the resident left three times without staff knowing. The family member could only recall one event in , when law enforcement found the resident approximately two miles from the facility. The family member said he understood the facility previously installed an alarm on the front door and cameras. He said the resident did not have any money with him and the family member had the resident's identification. On at 1:49 pm, the administrator said there were two prior times the resident left the facility without staff's knowledge but the incidents were not documented. On at 1:59 pm, the administrator presented a text message from her to the resident's family member, dated at 8:50 pm, where she indicated "he found the way to escape. We caught him in the front yard and got him in. Then he sat on the sofa on our porch. After that he had dinner and that is all." The administrator said the events of the elopement was that sometime after lunch she and the other staff realized the resident was not at the facility. A search was done inside and outside the facility, but he was not found. The administrator drove around the area. She received a call from the police letting her know they found him in a neighborhood, exact location	A 025		

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A 025	Continued From page 13	A 025		

unknown. She said the resident left through the front door and although it was alarmed, she did not hear it. She said the resident did not sustain injuries while out of the facility. The administrator explained in . . . . . sometime after lunch the resident packed personal items in a plastic bag. Afterwards he sat outside and spoke with his family member. At some point he walked out the front door. No staff saw him leave and the administrator did not hear the front door alarm sound. A search was conducted without success in locating him. She said someone in the community called the police and he was located in a residential area approximately one mile from the facility. The administrator noted the resident was tired and sitting in a shaded area on a curb when found. She described methods used to deter the resident from eloping were to put sports or religious programs on the television and offer him food. She added the resident constantly packed his personal items and said he was going to leave. She stated when the resident put his tennis shoes on, staff knew he was going to try to leave.

On at 2:28 pm, the administrator said that after the resident's elopement in . . . . . , she installed a motion detecting camera in the hallway, living room, kitchen and outside the front door. She said that sometime during . . . she turned the cameras off because every time a car went by and every time motion was detected within the facility, she received an alert on her phone, which became aggravating for her.

On at 2:36 pm, caregiver A said that on . . . . . at approximately 11:30 am she was in the kitchen when she saw the resident walk by, go out and sit on the sofa. Approximately 5 minutes later he came in and walked past

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	AL11965628	A. BUILDING: _____ B. WING _____	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL STARS ASSISTED LIVING, INC	1131 W LAKE BRANTLEY ROAD ALTAMONTE SPRINGS, FL 32714

(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 025	Continued From page 14	A 025		

her towards his room. She began serving lunch at 12 pm and went to look for him. She said he was not in his room and she looked for him inside and outside of the facility. She stated she drove around the neighborhood and did not see him. She then notified the administrator and later gave a statement to the police. She explained the resident did not verbalize any thoughts to leave that morning but packed his personal belongings like he did every day. She stated if he did talk about leaving, she redirected him with food, television, his cell phone or called his family member to speak with him. "Usually, the resident said he wanted to go to the bank, airport, to church or mentioned his family member." She recalled that day, the administrator gave the resident his medications that morning. She remembered the front door was locked when the caregiver went to look outside so she was confident the resident did not leave through the front door. She said the sliding glass door to the backyard was unlocked at the time but she did not see the resident walk past her to go to the porch. The caregiver said she regularly checked on him because of his tendency to want to leave. There were no specific times she did that, but she frequently saw him walking around.

On at 2:45 pm, the administrator said she believed the resident left via a door located behind the kitchen that led to the backyard and may have then gone through a hole in the fence.

On at 2:48 pm, caregiver B said, via translation by the administrator, that she saw the resident when she arrived to work on at 8 am. At approximately 11 am she saw him sitting on the sofa on the porch. He came shortly thereafter, and the caregiver saw him in his room. She learned the resident was missing

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A 025	Continued From page 15 from caregiver A and assisted in looking for the resident outside the facility. She stayed with the other residents while caregiver A continued the search. She said the resident normally said he wanted to leave but did verbalize wanting to leave that morning. On at 2:58 pm, the administrator said the facility did not conduct elopement drills because she did not know she had to. She said the elopement policy was created by the previous owner and she was in the process of becoming familiar with the policy. She said she called and went to local hospitals when the resident went missing but the resident was not there. She said the resident did not have money or identification (ID) when he left. She explained the facility did not have a procedure for ensuring residents had ID with them at all times. She noted that after the elopement, she spoke with the family member about getting a tracker, but nothing came of it. She contacted a camera company to install a separate monitoring and recording system that did not alarm on her phone but decided to wait until the end of this year to obtain a cost estimate. She recalled the resident lost his cell phone about a week prior to the most recent elopement while with a family member. She stated staff training post elopement consisted of her telling the staff that someone had to remain with the other residents during a search and if the resident was not found after 15-20 minutes to call police and notify her immediately. She explained that although the elopement policy indicated the facility would conduct an elopement risk assessment following changes and biannually, none were done because "his 1823 said he was not an elopement risk." On at 3:15 pm, the administrator said that	A 025		

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A 025	Continued From page 16 on Friday (. . . . .) she checked the door behind the kitchen with law enforcement and questioned why the alarm did not sound. Observations revealed two batteries were missing from the alarm panel and were on the floor near the door. The section of fence where the resident may have exited through now had a new panel that was placed on . The fence door on each side of the facility was secured with a padlock. The front door alarm was tested and worked during the survey. The alarm on the . . . sliding glass door was activated in the evening and was found to be functional. On . . . . . at 9:44 am, the resident's Advanced Practice Registered Nurse (APRN) said she was aware of the . . . . . elopement but not of the or incidents. She said she saw the resident once per month and recalled he wanted to go to Egypt. She explained he received some medications for agitation and stated he would not experience negative effects from not receiving his medications other than, "his might change." On at 12 pm, the administrator said she spoke with the resident's family member and told them if or when the resident returned, she would not discharge him immediately. She will give the family time to find somewhere else for the resident to live. She said in the meantime she will put one on one staff with the resident for his safety. The facility's undated elopement policy indicated changes in a resident's status in physical abilities, safety awareness or functional . . . . . status would be documented in the resident's file and should initiate a reassessment. The elopement risk assessment would be utilized to document	A 025		

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A 025	Continued From page 17 any changes. The facility would complete the risk assessment bi-annually. All staff would participate in a missing resident drill to practice appropriate responses at least two times per year and a record of the drill would be kept in the facility training records. All residents would be encouraged to carry ID information whenever they left the facility, including but not limited to, a picture ID and a card with the facility number and emergency contact information. After any missing resident event, the administrator/owner and responsible party should assess the on-going needs of the resident and if the facility was able to provide for those needs. If not, the facility should document the reasons and initiate an appropriate transfer/discharge protocol. The policy also indicated when a resident returns to the facility after an event in which the resident cannot be located, all appropriate parties should be notified, and an assessment of the resident's physical condition should be made. Contact the resident's physician and emergency medical personnel as needed. The incident specifics should be documented in the resident's medical file with notes reflecting the behavior and follow up notes on physical and medical status of the resident after the event. An after-event meeting with staff to determine the root cause of the event and what steps need to be taken to prevent a recurrence for that resident or other residents. The meeting shall be documented and kept with the facility files. Training should be held and documented in facility files. Class I	A 025		
A 032 SS=G	59A-36.007(7) FAC Resident Care - Elopement Standards	A 032		

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A 032	Continued From page 18 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		

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A 032	Continued From page 19 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 reviews and interviews, the facility failed to conduct resident elopement drills, failed to make a daily effort to ensure 2 of 2 sampled residents at risk for elopement had ID on their person that included their name and the facility's name, address and phone number and had an elopement assessment (#1 & #11) and failed to include as part of its elopement policy the facility would make a daily effort to ensure residents at risk for elopement had ID on their person. Findings: 1. A facility incident report indicated that on unlicensed caregiver A last saw resident	A 032		

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A	Continued From page 20 #1 at approximately 11:30 am when he went out to the porch. Approximately 5 minutes later he came inside and went to his room. At 12:30 pm caregiver A began serving lunch but could not find the resident. A search by the staff of the inside and outside did not locate the resident. The administrator was notified, who called the resident's family and law enforcement. Nearby hospitals were called and visited, and the resident was not located. Law enforcement conducted a search with the use of police dogs, drones, and helicopters without success. A review of resident #1's record revealed a facility admission date of . The resident's medical history included 's with behavioral disturbance, , and Major , . The resident ambulated independently without the aid of an assistive device and was considered a risk. He needed assistance with self-administration of medications. Health assessment forms (1823) dated , and all indicated the resident was not an elopement risk. A facility note indicated the resident spoke with his family member and was concerned about another family member. He thought the other family member was sick and he wanted to go see them. He asked for a passport to go to the airport. After lunch he forgot about it and stayed in his room. A 12 pm, a facility note indicated the resident had the idea to get out of the facility. To distract him, the administrator took the resident to buy groceries.	A 032		

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A 032	Continued From page 21 A . . . . . facility note indicated the search continued to find the resident when he could not be located at 12:30 p.m. when staff began serving lunch. The staff collaborated with the authorities and maintained communication with the family. A 5:30 pm facility note indicated the facility collaborated with the police department by providing information to the best of their ability. On at 12:41 pm, the resident's family member said the resident always tried to leave the facility and verbalized wanting to go to take a bus to go to Egypt and wanting to obtain a passport to go see his family in Egypt. The family said under the facility's current owner, the resident left three times without staff knowing. The family member could only recall one event in when law enforcement found the resident approximately two miles from the facility. The family member said he understood the facility previously installed an alarm and cameras on the front door. He said the resident did not have any money with him and the family member had the resident's ID. On at 1:49 pm, the administrator said there were two prior times the resident left the facility without staff's knowledge but the incidents were not documented. On . . . . at 1:59 pm, the administrator presented a text message from her to the resident's family member, dated . . . . . at 8:50 pm, where she indicated "he found the way to escape. We catch him at the front yard and got him in. Then he sat at the sofas at our porch. After that he has his dinner and that is all." The administrator said the events of the	A 032		

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A 032	Continued From page 22 elopement was that sometime after lunch she and the other staff realized the resident was not at the facility. A search was done inside and outside the facility, but he was not found. The administrator drove around the area and received a call from the police letting her know they found him in a neighborhood, exact location unknown. She said the resident left through the front door and although it was alarmed, she did not hear it. She said the resident did not sustain injuries while out of the facility. The administrator explained in . . . . . sometime after lunch the resident packed personal items in a plastic bag. Afterwards he sat outside and spoke with his family member. At some point he walked out the front door but staff did not see him leave and the administrator did not hear the front door alarm sound. She recalled a search was conducted without success in locating him. She started someone in the surrounding community called the police and the resident was located in a approximately one mile from the facility. She said the resident was tired and sitting in a shaded area on a curb when found and was not injured. She said methods used to deter the resident from eloping were to put sports or religious programs on the television and give him food. She said the resident constantly packed his personal items and said he was going to leave. She said when the resident put his tennis shoes on staff knew he was going to try to leave. On . . . . at 2:58 pm, the administrator said the facility did not conduct elopement drills because she did not know she had to. She said the elopement policy was created by the previous owner and she was in the process of getting familiar with it. She explained the resident did not	A 032		

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A 032	Continued From page 23 have any money or identification with him when he went missing. She called and went to local hospitals to check for the resident but he was not there. She acknowledged the facility did not have a procedure for ensuring residents had ID with them at all times. She said that although the elopement policy indicated the facility would conduct an elopement risk assessment following [illegible] changes and biannually, none were done for the resident as "his 1823 said he was not an elopement risk." 2. review of resident #11's record revealed a facility admission date of [illegible]. The resident's medical history included [illegible], current episode depressed, severe, with [illegible] features, [illegible], and [illegible]. A [illegible] 1823 identified him as an elopement risk. The resident ambulated independently. On [illegible] at 11:57 am, the administrator said the resident did not have ID and a daily effort was not made by staff to ensure he did. She said "most of the time he's in bed. He's compliant." The administrator said an elopement assessment per the policy was not done. She said she did an assessment which consisted of asking the resident if he was alert and oriented, asked him if he felt depressed, if he was happy and if by any chance he wanted to go out. On [illegible] at 3:10 pm, resident #11 said he did not have ID. The facility's undated elopement policy indicated changes in a resident's status in physical abilities, safety awareness or functional [illegible] status would be documented in the resident's file and should initiate a reassessment. The elopement	A 032		

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A 032	Continued From page 24 risk assessment would be utilized to document any changes. The facility would complete the risk assessment bi-annually. All staff would participate in a missing resident drill to practice appropriate responses at least two times per year and a record of the drill would be kept in the facility training records. All residents would be encouraged to carry ID information whenever they left the facility, including but not limited to, a picture ID and a card with the facility number and emergency contact information. Class II	A 032		
A 077 SS=G	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement.	A 077		

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A 077	Continued From page 25 Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least [illegible]; 2. If employed on or after [illegible], have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to [illegible], are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances,	A 077		

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A 077	Continued From page 26 such as the . . . . of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile . . . . of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , . , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not . . . . . , serve as an administrator	A 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965628	A. BUILDING: _____ B. WING _____	05/14/2024

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A 077	Continued From page 27 of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the administrator, who was responsible for the management of all staff and the provision of appropriate care to all residents, failed to ensure: 1. adequate supervision was provided when 1 of 11 sampled residents eloped three times from the facility (#1.) 2. resident elopement drills were conducted. 3. staff made, at a minimum, a daily effort to ensure 2 of 2 sampled residents at risk for elopement had identification (ID) on their person that included their name and the facility's name, address and phone number and had an elopement assessment (#1 & #11) and that the elopement policy contained the same language. 4. the facility's elopement policy was used when 3 of 3 sampled staff were trained on the topic (A, B, C.) 5. a new background screening was submitted for 1 of 3 sampled staff who had a break in service of more than 90 days from a position that required screening (C.) 6. a preliminary report was submitted to AHCA within 1 business day and a full report within 15	A 077		

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A 077	Continued From page 28 days of 1 of 11 sampled residents eloping from the facility (#1.) Findings: 1. A facility incident report indicated that on [redacted] unlicensed caregiver A last saw resident #1 at approximately 11:30 am when he went out [redacted] and sat on a sofa. Approximately 5 minutes later he came inside and went to his room. At 12:30 pm caregiver A began serving lunch. She went to get the resident and could not find him. A search by the staff of the inside and outside did not locate the resident. The administrator was notified, who called the resident's family and law enforcement. Nearby hospitals were called and visited, and the resident was not located. Law enforcement conducted a search with the use of police dogs, drones, and helicopters without success. A review of resident #1's record revealed a facility admission date of [redacted]. The resident's medical history included 's with behavioral disturbance, [redacted], and Major , [redacted]. The resident ambulated independently without the aid of an assistive device and was considered a risk. He needed assistance with self-administration of medications. , and health assessment forms (1823) all indicated he was not an elopement risk. A facility note indicated the resident spoke with his family member and was concerned about another family member. He thought the other family member was sick and he wanted to go see them. He asked for a passport	A 077		

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A 077	Continued From page 29 to go to the airport. After lunch he forgot about it and stayed in his room. A 12 pm facility note indicated the resident had the idea to get out of the facility. To distract him he went out with the administrator to buy groceries. A facility note indicated the search continued to find the resident, continued to find the resident when he could not be located at 12:30 p.m., when staff began serving lunch. The staff collaborated with the authorities and maintained communication with the family. A 5:30 pm facility note indicated the facility collaborated with the police department by providing information to the best of their ability. A review of the resident's Medication Observation Record (MOR) revealed he was prescribed the following medications: D 2,000-unit 1 tablet once daily for supplement. 50 milligrams (mg) 1 tablet three times daily for . 0.5 mg half-tablet daily at noon for 5 mg 1 tablet twice daily for 0.5 mg 1 tablet twice daily for 10 mg 1 tablet twice daily for 3 mg 1 capsule twice daily for The facility last gave him the medications on the morning of .	A 077		

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A 077	Continued From page 30 On .. ... at 12:41 pm, the resident's family member said the resident always tried to leave the facility and verbalized wanting to go to Egypt. He verbalized wanting to take a bus to Egypt. He verbalized wanting to obtain a passport to go see his family member in Egypt. The family said under the facility's current owner the resident left three times without staff knowing. The family member could only recall one event in . . when law enforcement found the resident approximately two miles from the facility. The family member said he understood the facility previously installed an alarm on the front door and cameras. He said the resident had no money on him and the family member had the resident's identification. On at 1:49 pm, the administrator said there were two prior times the resident left the facility without staff knowing. The administrator said the incidents were not documented nor was it a preliminary and a 15-day report submitted to AHCA. On .. ... at 1:59 pm, the administrator presented a text message from her to the resident's family member, dated ... ... at 8:50 pm, where she indicated "he found the way to escape. We caught him in the front yard and got him in. Then he sat on the sofas at our porch. After that he has his dinner and that is all." The administrator said the events of the elopement was that sometime after lunch she and the other staff realized the resident was not at the facility. A search was done inside and outside the facility, but he was not found. The administrator drove around the area. She received a call from the police letting her know they found him in a neighborhood, exact location unknown. She said the resident left through the	A 077		

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A 077	Continued From page 31	A 077		

front door and although it was alarmed, she did not hear it. She said the resident did not sustain injuries while away from the facility.

The administrator went on to say that in sometime after lunch the resident packed personal items in a plastic bag. Afterwards he was sitting on the sofa and spoke with his family member. At some point he walked out the front door. No staff saw him leave and the administrator did not hear the front door alarm sound. At some point the staff did not see him so a search was conducted without success in locating him. Someone in the surrounding community called the police. The resident was located in a neighborhood approximately one mile from the facility. The administrator said the resident was tired and sitting in a shaded area on a curb when found. She said otherwise the resident was not injured. She said methods used to deter the resident from eloping were to put sports or religion on the television and give him food. She said the resident constantly packed his personal items and said he was going to leave. She said when the resident put his tennis shoes on staff knew he was going to try to leave.

On at 2:28 pm, the administrator said that after the resident's elopement in she installed a motion detecting camera in the hallway, living room, kitchen and outside the front door. She said that sometime during she turned the cameras off because every time a car went by and every time motion was detected within the facility, she received an alert on her phone, which became aggravating to her.

On at 2:36 pm, caregiver A said that on at approximately 11:30 am she was in the kitchen when she saw the resident walk by, go

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A 077	Continued From page 32 out . . . and sit on the couch. Approximately 5 minutes later he came in and walked past her towards his room. She began serving lunch at 12 pm. She went looking for him for lunch. He was not there so she looked inside and outside the facility. She drove around the neighborhood and did not see him. She called the administrator then returned to the facility. The police came and she gave a statement. The resident did not verbalize to her that morning a desire to leave. The resident packed personal belongings every day. She redirected him with food, television, his cell phone or calls his family member to speak with him. Usually, the resident said he wants to go to the bank, airport, to church or mentions his family member. The administrator gave the resident his medications that morning then left. The front door was locked when the caregiver went to look outside so she was confident the resident did not leave through that door. The sliding glass door to the backyard was unlocked at the time. She did not see the resident walk past her again to go to the porch. The caregiver said she regularly checked on him because of his tendency to want to leave. There were no specific times she did that, but she frequently saw him walking around. On . . . . . at 2:45 pm, the administrator said she believed the resident left via a door located behind the kitchen that led to the backyard and may have then gone through a hole in the fence. On at 2:48 pm, caregiver B said, via translation by the administrator, that she saw the resident when she arrived to work on at 8 am. At approximately 11 am she saw him sitting on the sofa on the porch. He came shortly thereafter, and the caregiver saw him in his room. She learned the resident was missing	A 077		

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A 077	Continued From page 33 from caregiver A. She looked outside the facility. She stayed with the other residents while caregiver A continued the search. She said the resident normally said he wanted to leave but did not on that morning. On . . at 2:58 pm, the administrator said the facility did not conduct elopement drills because she did not know she had to. She said the elopement policy was created by the previous owner and she was in the process of getting to know them. She said she called and went to local hospitals and the resident was not there. She said the resident did not have money or identification (ID) when he left. She said the facility did not have a procedure for ensuring residents had ID. She said that after the elopement she spoke with the family member about getting a tracker, but nothing came of it. She contacted a camera company to install a separate monitoring and recording system that does not go to her phone. She decided to wait until the end of this year to obtain a quote for the work. She said the resident lost his cell phone about a week prior to the most recent elopement while with a family member. She said staff training post elopement consisted of her telling the staff that someone had to remain with the other residents during a search and if the resident was not found after 15-20 minutes call police and notify her immediately. She said she was previously considering discharging the resident, but his family wanted him to stay. She said that although the elopement policy indicated the facility would conduct an elopement risk assessment following changes and biannually, none were done because "his 1823 said he was not an elopement risk." On at 3:15 pm, the administrator said that	A 077		

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A 077	Continued From page 34 on Friday ( ) she checked the door behind the kitchen with law enforcement. She wondered why the alarm did not sound. Two batteries were missing from it and were on the floor near the door. The section of fence where the resident may have exited through now had a new panel that was placed on . The fence door on each side of the facility was secured with a padlock. The front door alarm was working during the survey. The alarm on the sliding glass door is activated in the evening. It worked during the survey. On at 9:44 am, the resident's Advanced Registered Nurse Practitioner (APRN) said she was aware of the elopement but not of the or times. When asked if the resident may experience negative effects from not receiving his medications she replied "not really. His might change." She said the resident's goal was to get to Egypt. She said the resident gets agitated and that was why he was prescribed the medications. She sees the resident once a month. On at 12 pm, the administrator said she spoke with the resident's family member and told them if or when the resident returned, she would not kick the resident out. She will give the family time to find somewhere else for the resident to live. She said in the meantime she will put one on one staff with the resident. The facility's undated elopement policy indicated changes in a resident's status in physical abilities, safety awareness or functional status would be documented in the resident's file and should initiate a reassessment. The elopement risk assessment would be utilized to document any changes. The facility would complete the risk	A 077		

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A 077	Continued From page 35 assessment bi-annually. All staff would participate in a missing resident drill to practice appropriate responses at least two times per year and a record of the drill would be kept in the facility training records. All residents would be encouraged to carry ID information whenever they left the facility, including but not limited to, a picture ID and a card with the facility number and emergency contact information. After any missing resident event, the administrator/owner and responsible party should assess the on-going needs of the resident and if the facility was able to provide for those needs. If not, the facility should document the reasons and initiate an appropriate transfer/discharge protocol. The policy also indicated when a resident returns to the facility after an event in which the resident cannot be located, all appropriate parties should be notified, and an assessment of the resident's physical condition should be made. Contact the resident's physician and emergency medical personnel as needed. The incident specifics should be documented in the resident's medical file with notes reflecting the behavior and follow up notes on physical and medical status of the resident after the event. An after-event meeting with staff to determine the root cause of the event and what steps need to be taken to prevent a recurrence for that resident or other residents. The meeting shall be documented and kept with the facility files. Training should be held and documented in facility files. review of resident #11's record revealed a facility admission date of . The resident's medical history included , 1 , current episode depressed, severe, with , , features, , , , , and . A	A 077		

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A 077	Continued From page 36 1823 identified him as an elopement risk. The resident ambulated independently. On at 11:57 am, the administrator said the resident did not have ID and a daily effort was not made by staff to ensure he did. She said "Most of the time he's in bed. He's compliant." The administrator said an elopement assessment per the policy was not done. She said she did an assessment which consisted of asking the resident if he was alert and oriented x3. She asked him if he felt depressed, if he was happy there and if by any chance he wanted to go out. On at 3:10 pm, resident #11 said he did not have ID. The facility's undated elopement policy indicated changes in a resident's status in physical abilities, safety awareness or functional status would be documented in the resident's file and should initiate a reassessment. The elopement risk assessment would be utilized to document any changes. The facility would complete the risk assessment bi-annually. All staff would participate in a missing resident drill to practice appropriate responses at least two times per year and a record of the drill would be kept in the facility training records. All residents would be encouraged to carry ID information whenever they left the facility, including but not limited to, a picture ID and a card with the facility number and emergency contact information. 2. A review of personnel records revealed the following: Caregiver A was hired on . She received a 1-hour online training on elopement and on .	A 077		

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A 077	Continued From page 37 Caregiver B was hired on . She received a 1-hour training on elopement and on . Caregiver C was hired on . She received a 1-hour training on elopement and on . None of the records contained documentation to indicate the training included the elopement policy and that they were given a copy of the policy. On at 11:22 am, the administrator said the only curriculum used for the training was from an online source and she used the curriculum to provide verbal reinforcement. She said it did not include the elopement policy. She said she planned to put together her own portfolio of curriculum. On at 11:43 am, the administrator returned and said she did have the staff read the elopement policy then gave them the opportunity to ask questions. She said a copy of the policy was not given to the staff. The facility's undated elopement policy indicated facility staff would be trained during orientation about signs and symptoms residents may exhibit which may lead to a resident being at risk for elopement and what activities staff can do to redirect or avoid escalation of such behaviors. 3. A review of caregiver C's personnel record revealed a hire date of . A review of the background screening website on at 11 am revealed a eligible background screening. It also revealed an	A 077		

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A 077	Continued From page 38 employment end date of from her most recent position that required screening. Therefore, the facility should have submitted a request for a new screening. On at 11:16 am, the administrator said she did not submit a new request because she did not know it was required. Class II	A 077		
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 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 081		

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A 081	Continued From page 39 (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel 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	A 081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965628	A. BUILDING: _____ B. WING _____	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL STARS ASSISTED LIVING, INC	1131 W LAKE BRANTLEY ROAD ALTAMONTE SPRINGS, FL 32714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 081	Continued From page 40 home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 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.	A 081		

Agency for Health Care Administration

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A 081	Continued From page 41 (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 reviews and interviews, the facility failed to use its resident elopement policy when 3 of 3 sampled staff were trained on the topic (A, B, C.) Findings: A review of personnel records revealed the following: Caregiver A was hired on . She received a 1-hour online training on elopement and on . Caregiver B was hired on . She received a 1-hour training on elopement and on .	A 081		

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A 081	Continued From page 42 Caregiver C was hired on . She received a 1-hour training on elopement and on . None of the records contained documentation to indicate the training included the elopement policy and that they were given a copy of the policy. On at 11:22 am, the administrator said the only curriculum used for the training was from an online source and she used the curriculum to provide verbal reinforcement. She said it did not include the elopement policy. She said she planned to put together her own portfolio of curriculum. On at 11:43 am, the administrator returned and said she did have the staff read the elopement policy then gave them the opportunity to ask questions. She said a copy of the policy was not given to the staff. The facility's undated elopement policy indicated facility staff would be trained during orientation regarding signs and symptoms residents may exhibit which may lead to a resident being at risk for elopement and what activities staff can do to redirect or avoid escalation of such behaviors. Class III	A 081		