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
	AL11969485	A. BUILDING: _____ B. WING _____	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HARBOR	370 BLARNEY ST PORT CHARLOTTE, FL 33954

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced relicensure, emergency power plan, health facility reporting system, generator, and visitation form survey was conducted on [redacted] at Sunshine Harbor, an assisted living facility in Port Charlotte, Florida. The following is a description of the deficiencies.	A 000		
A 025 SS=G	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 [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. 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 [redacted] 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 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,	A 025		

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A 025	Continued From page 1 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 record review, and interview, the facility failed to provide adequate supervision to maintain a general awareness of the resident's whereabouts for 1 (Resident #6) of 1 Resident reviewed. The findings Included: Record review of Resident #6's clinical record revealed a residency agreement signed . Further review revealed Health Assessment Form (1823) signed by the provider on	A 025		

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A 025	Continued From page 2 indicated Resident #6 had a medical diagnosis of , , essential , , , , type, with a status of paranoia and thought process. On at 8:55 a.m. during observation of medication observation, Med Tech Staff A entered Resident #6's room to assist with medications and Resident #6 was not in the room. Staff A said she could not find Resident #6 in the bathroom or kitchen. Staff A informed the Owner of the facility who said he had not seen Resident #6. Staff A spoke with the Administrator who said she had not seen Resident #6. The owner drove around the community searching for Resident #6. On at 9:00 a.m., Staff A stated the last time she saw Resident #6 was on at 10:15 p.m. and she did not see or hear him leave the facility. Staff A said yesterday, , the resident's uncle came for a visit and they sat outside and smoked. Staff A stated Resident #6 kept going in and out the rear door saying he was going downtown. Staff A stated she gave Resident #6 his meds at 8:00 p.m. and saw him after, he was walking around in the building saying he was going downtown. Staff A said, "he was saying crazy things last night, and she is not sure if the gate was closed." Staff A stated the gate at the rear of the facility can shut, sometimes they close it but it is mostly always open. Staff A confirmed the first time she realized Resident #6 was missing and not in the building was when she went to give him his medication this morning. On at 10:30 a.m. in an interview with the owner of the facility, he stated residents in the facility go to bed at about 10:00 pm and staff are	A 025		

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A 025	Continued From page 3 to check on residents during the night to make sure the residents are okay and safe. The Owner of the facility confirmed from his discussion with Staff A, Resident #6 was not seen or checked on since last seen at 10:15 p.m. last night, ... On ..... at 11:25 a.m., Staff A confirmed she did not check on Resident #6 or the other residents in the facility after she saw Resident #6 at 10:30 p.m. on . On at 3:30 p.m. in an interview with Charlotte County Sheriff's Deputy who responded to the call stated when he reached the department, he searched the database and found Resident #6 was picked up by the police at the corner of Veterans boulevard and Atwater street at 4:16 a.m. this morning, . The Deputy said the resident was having mental issues and was to Charlotte Regional Behavioral Center. Class II	A 025		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming	A 052		

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A 052	Continued From page 4 that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a , of the body.	A 052		

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A 052	Continued From page 5 (d) Administration of , , , , , , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally	A 052		

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A 052	Continued From page 6	A 052		

advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed.
(c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container.
(d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record.
(e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed:
1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility,
2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record,
3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or
4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging.
(f) Assistance with self-administration of medication does not include the activities detailed

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A 052	Continued From page 7 in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's . . . . control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure staff who assist with self-administration of medications do so in accordance with proper procedure for 5 (Residents # 1, # 2, # 3, #4, # 5) of 5 medications observations. The facility failed to maintain proper documentation of the Medication Observation Record (MOR) by staff completing documentation when performing assistance with self-administration of medications for 1(Resident #6) of 1 resident reviewed. The findings included: Facility policy Assistance with Medications by Unlicensed Personnel: Assisted Living Facility (ALF) state statutes permit an ALF to assist residents with self-administered medications by un-licensed staff or administer medications to residents if the facility has a licensed nurse on staff. Under ALF statutes " assistance with self-administered medications means" that trained unlicensed staff can help a person to self-administer their medications by performing such tasks as bringing the resident's medications to the resident , reading the prescription label and removing the prescribed amount of medication from the container, placing the medications in the	A 052		

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A 052	Continued From page 8 resident . . . or in another container and helping the resident to lift it to their ; applying . . , . . . medications; returning the medication to storage; and keeping a record of medications that the resident has self-administered. On . . . . . at 8:40 a.m. during med pass observation, Med Tech Staff A removed cups with pills for all 6 facility residents from a cabinet in the office, all cups were marked with residents' names and were on a tray with 2 . . . . . machines. On at 8:41 a.m., observed Staff A left the tray of 6 souffle cups with pills pre-poured for the residents with their names on the cups on a table in the living room area unattended. The 2 . machines were also on the tray. Staff A went into the kitchen for 2 minutes. Staff A returned to the living room and donned gloves without performing . . hygiene and proceeded down the hallway to the residents' rooms. On at 8:43 a.m., observed Staff A take the tray of medication into Resident #5's room calling him by name and said, " I'm just here to give you your meds." Staff A gave Resident #5 a cup marked with his name. Staff A did not tell Resident #5 what medications he was given. Staff A did not document the medications for Resident #5 when given. Staff A continued to the next resident, still wearing the gloves, no hygiene performed between residents. On . . . . at 8:44 a.m., observed Staff A take the tray of medication into Resident #4's room, call him by name and say, "Alright, I'm going to give you your meds". Staff A did not tell Resident #4 what meds he was given. Staff A did not perform hygiene before assisting Resident	A 052		

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A	Continued From page 9 #4 with his meds. Staff A continued wearing the same gloves. Staff A pointed out the resident was slumping in the bed and attempted with one to reposition him with little outcome. Staff A then stuck her gloved into the waistband of Resident #4's adult brief and peaked to see if he was soiled. Staff A continued to the next resident, without performing hygiene, still wearing the same gloves. On at 8:46 a.m., observed Staff A enter Resident #2's room and say, "good morning , you have to get up, time for your meds". Staff A proceeded to check the resident's . Staff A cleaned Resident #2's thumb with an wipe, pricked the thumb, dabbed onto an Accu-Chek strip, and placed the strip into the for a reading of 95. Staff A proceeded to Resident #2 the cup marked with her name and spilled the meds onto the tray. Staff A picked up the pills with gloved and returned them to the cup then gave Resident #2 the cup with the pills. Staff A did not change gloves before and after Accu-check for and did not perform hygiene. Staff A did not tell Resident #2 what medications she was given. Staff A did not document the readings and or the medications given. On at 8:49 a.m., observed Staff A enter Resident #3's room call her by name and say, "I got your pills for you". Staff A gave Resident #3 the cup marked with her name. Staff A did not tell the resident what meds were given, no hygiene performed, did not change gloves (still wearing same gloves from assisting previous residents), and did not document the medications given to Resident #3. On at 8:51 a.m., observed Staff A enter	A 052		

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A 052	Continued From page 10 Resident #1's room, call him by name and say, "Alright, I'm going to give you your pills." Staff A gave the Resident #1 the cup marked with his name, still wearing gloves from previous residents, no hygiene performed. Staff A cleaned Resident #1's thumb with an wipe, pricked the thumb, and dabbed . . . onto an Accu-check strip. Staff A place the strip in the . . . . . which failed to produce a reading. Staff A informed Resident #1, she needed to stick him again, using a different . Staff A stuck Resident #1 on his index ran another strip through the . . . . and got a reading of 144. Staff A thanked the resident and left the room. Staff A did not tell Resident #1 what meds he was given, no hygiene performed between residents, gloves were not changed between residents, and staff A did not document the . . . . reading or what medications were given to Resident #1. On at 8:55 a.m., Observed Staff A go to Resident #6's room and discover the resident was not there. After 15 minutes of searching for Resident #6, Staff A took the tray with Resident #6's medications to the front office and left it on a table. A review of the Medication Observation Record for Resident #6 revealed the form was blank. There were no medications listed and no information for Resident #6 documented on the MOR. On . . . . at 9:41 a.m., the Administrator stated the FACT team sent Resident #6's , medications to the facility, which the Med Tech has been giving out. The Administrator confirmed the MOR for Resident #6 has no medications listed and medications taken since admission to	A 052		

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A 052	Continued From page 11 the facility were not documented. The administrator confirmed she has no documentation to indicate Resident #6 was given any medications by the Med Techs. On at 10:10 a.m. in an interview, the Case Manager for Resident #6 stated the resident moved into the facility over 1 week ago on and the facility was provided with Resident #6's , , medications. The Case Manager said facility staff are to assist the resident with his meds due to his diagnosis. On at 10:41 a.m., the facility owner stated the med techs give the residents the medications in the cup at breakfast when they are sitting at the dining table. The owner stated the meds are prepared by the nurse, she reviews and checks the meds and prepares them for the med tech to give to the residents. He said the med techs are to inform the resident what meds they are being given. On at 10:50 a.m., the Administrator stated she prepares the medications and puts them in the pill box. She said the med tech takes the meds from the pill box and puts them into cups, takes the cups with the pills and gives the meds to the residents. She said the med techs are to tell the resident what meds she is giving them. The Administrator stated the med techs are to take the copy of the MOR that is attached to the pill box, highlighted with the meds in the pill box and tell the residents what they are being given. The Administrator said the med techs are to perform hygiene before and in between each resident, and if using gloves when the gloves are removed they are to perform hygiene. The administrator stated the med tech	A 052		

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A 052	Continued From page 12 does not sign the MOR after giving the meds. The Administrator said she speaks with the med techs and asks if they have given the medications and then she herself signs the MORs. The administrator stated she does it this way so that she can make sure the meds are prepared correctly. The Administrator confirmed that staff A did not assist the resident with the medication pass appropriately. On . . . . at 11:25 a.m., Med Tech Staff A stated the administrator prepares the meds for the residents in the pill boxes and leaves them on the tray. Staff A said she gets the tray of medications and . . . . . them out to the residents. Staff A confirmed she does not sign the MOR when she gives the med, she stated the administrator signs the MOR. Class III	A 052		
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	A 081		

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A 081	Continued From page 13 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 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	A 081		

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	AL11969485	A. BUILDING: _____ B. WING _____	03/26/2024

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A 081	Continued From page 14 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 [illegible] control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its [illegible] control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to [illegible] borne [illegible], 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 [illegible], neglect, and [illegible]. The facility must use its [illegible] prevention policies and procedures when	A 081		

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A 081	Continued From page 15 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 staff interview, the facility failed to ensure facility employees complete required training within 30 days of hire to include 1 hour of training for . . . . , Neglect and , and 3 hours of ADL and Behavioral needs training for 1 (Staff A) out of 2 staff records reviewed	A 081		

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A 081	Continued From page 16 The findings included: Record review of Staff A's employee file revealed a hire date of [redacted] as a Med Tech/Caregiver. Staff A's file contained no documentation of having completed 1 hour of training for [redacted], Neglect and [redacted] and 3 hours of ADL and Behavioral Needs training. During an interview on [redacted] at 1:34 p.m., the Administrator reviewed Staff A's employee record and confirmed no documentation of completed [redacted] training and ADL training. Class III	A 081		
A 082 SS=D	59A-36.011(4) FAC Training - [redacted] / (4) [redacted] (/). 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 [redacted], including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure facility employees complete a one-time education course on [redacted] and [redacted] (/) within 30 days	A 082		

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A 082	Continued From page 17 of employment for 1 (Staff A) of 2 employee files reviewed. The findings included: Record review of Staff A's employee file revealed a hire date of [redacted] as a Med Tech/Caregiver. Staff A's file contained no evidence of training being completed within 30 days of employment for / . During an interview on at 1:34 p.m., the Administrator reviewed Staff A's employee record and confirmed no documentation of completed training for / . Class III	A 082		
A 085 SS=D	59A-36.011(7) FAC Training - Nutrition & Food Service (7) NUTRITION AND FOOD SERVICE. The administrator or person designated by the administrator as responsible for the facility's food service and the day-to-day supervision of food service staff must obtain, annually, a minimum of 2 hours continuing education in topics pertinent to nutrition and food service in an assisted living facility. This requirement does not apply to administrators and designees who are exempt from training requirements under paragraph 59A-36.012(1)(b). A certified food manager, licensed dietician, registered dietary technician or health department sanitarian is qualified to train assisted living facility staff in nutrition and food service. This Statute or Rule is not met as evidenced by:	A 085		

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A 085	Continued From page 18 Based on record review and interview, the facility failed to ensure the person responsible for food service obtain 2 hours of continuing education in nutrition and food service annually for 1 (Administrator) of 2 employee files reviewed. The findings included: On ..... at 12:50 p.m., the administrator states she is the food service designee for the facility and is responsible for making sure the menus are updated and purchasing the food for the facility. Record review of the employee file for the administrator revealed a hire date of ..... There was no documented completion of continuing education in nutrition and food service annually. On at 1:58 pm, the Administrator reviewed her employee record and confirmed there was no documentation of completion of 2 hours of continuing education in nutrition and food service annually. Class III	A 085		
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, 5. Place of birth, if known, 6. Social security number,	A 162		

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A 162	Continued From page 19 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 such consent is not included in the resident's contract.	A 162		

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A 162	Continued From page 20 (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 [illegible] recipient, a copy of the Department of Children and Families form Alternate Care Certification for [illegible], CF-ES 1006, [illegible], 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 [illegible] 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 hospice patient as required in Rule 59A-36.006, F.A.C.	A 162		

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A 162	Continued From page 21 (o) The resident's . . . . . , 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 ensure they maintained resident records with required documents to include resident demographics data on file at the facility as required for 1 (Resident #6) of 3 resident records reviewed. The findings included: On . . . . at 9:30 a.m., the Administrator stated the Resident #6 moved to the facility on Tuesday the 19th. On at 9:34 a.m., Request was made to administrator for the clinical chart for the Resident	A 162		

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A	Continued From page 22 #6. Record Review of Resident #6 clinical record revealed he was admitted to the facility on ..... there was no evidence of demographics sheet to include, name, date of admit, , date of birth, place of birth, name, address and telephone of next of kin for notification in case of emergency, and name, address and telephone number of healthcare provider on file at the facility in the clinical record. On ..... at 9:37 a.m., the Administrator provided the clinical record for Resident #6 and said, " I have not been able to do anything with it yet." On at 10:30 a.m., The Administrator reviewed Resident #6's clinical record and confirmed no demographic sheet in the record. Class III	A 162		