

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969602</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/01/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ROSARIO ASSISTED LIVING FACILITY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2616 22ND ST W<br/>LEHIGH ACRES, FL 33971</b>                                |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 000                                                                       | Initial Comments<br><br>An unannounced abbreviated state relicensure, emergency power plan monitoring, health facility reporting system, and visitation form survey was conducted on _____ at Rosario Assisted Living Facility, an assisted living facility in Lehigh Acres, Florida.<br><br>The following is a description of the deficiency.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | A 000                                                                          |                                                                                                                          |  |                                                        |
| A 077<br>SS=D                                                               | 429.176 FS; 429.52( ), 59A-36.01(1) FAC<br>Staffing Standards - Administrators<br><br>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.<br><br>429.52<br>(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. Other licensed professionals may be exempted, as determined by the agency by rule.<br>(5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. | A 077                                                                          |                                                                                                                          |  |                                                        |

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ROSARIO ASSISTED LIVING FACILITY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2616 22ND ST W<br/>LEHIGH ACRES, FL 33971</b> |                                                                                                                          |                                                        |
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| A 077                                                                       | <p>Continued From page 1</p> <p>59A-36.010</p> <p>(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.</p> <p>(a) An administrator must:</p> <ol style="list-style-type: none"> <li>1. Be at least _____;</li> <li>2. If employed on or after _____, have, at a minimum, a high school diploma or G.E.D.;</li> <li>3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.;</li> <li>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 _____, are not required to take the competency test unless specified elsewhere in this rule; and,</li> <li>5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C.</li> </ol> <p>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.</p> <p>(b) In the event of extenuating circumstances, 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</p> | A 077                                                                                     |                                                                                                                          |                                                        |

Agency for Health Care Administration

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| A 077                                                                       | <p>Continued From page 2</p> <p>to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must:</p> <ol style="list-style-type: none"> <li>1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and,</li> <li>2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility.</li> </ol> <p>(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.</p> <p>(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 of any other facility.</p> <p>(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</p> | A 077                                                                                     |                                                                                                                          |                                                        |

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**ROSARIO ASSISTED LIVING FACILITY**

**2616 22ND ST W  
LEHIGH ACRES, FL 33971**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
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| A 077                    | <p>Continued From page 3</p> <p>form, AHCA Form 3180-1006, _____, which is incorporated by reference and available online at:<br/><a href="http://www.flrules.org/Gateway/reference.asp?No=Ref-09393">http://www.flrules.org/Gateway/reference.asp?No=Ref-09393</a>.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on record review, and staff interview, the facility failed to ensure that facility's appointed manager met the regulatory requirements.<br/>Facility's manager failed to take the CORE competency test within 90 days of accepting the manager's position.</p> <p>Findings included:</p> <p>Record review showed that administrator is the owner/administrator for a total of two facilities.</p> <p>During an interview on _____ at 11:30 a.m., the Administrator said she appointed Staff A as the facility's manager on _____.</p> <p>Record review for Staff A showed that she completed the assisted living facility CORE training on _____. Further review found no evidence that Staff A took the CORE competency test and subsequently passed the exam.</p> <p>During an interview on _____ at 3:40 p.m., the Administrator acknowledged that Staff A did not take the CORE competency test and subsequently did not obtain a passing score. Administrator said she will try to find a new manager as soon as possible.</p> <p>Class III</p> | A 077               |                                                                                                                          |                          |