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
	AL11969874	A. BUILDING: _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE LIVING AT MAITLAND	701 N MAITLAND AVE MAITLAND, FL 32751

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A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . . . . . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative . . . . . examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . . . . . . 2. If any staff member has, or is suspected of having, a communicable . . . . . , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document	A 078		

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A 078	Continued From page 1 observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility . . . . . to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to ensure 1 of 7 sampled staff (E) had evidence of an annual negative . . . . ( ) examination and a provider's health care statement. Findings: In a personnel record for unlicensed caregiver E, revealed a hire date of . There was no documented evidence of the required annual examination or the provider's health statement stating he does not constitute a risk of communicating .	A 078		

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A 078	Continued From page 2 On at 11 AM, an interview with the Business Office Manager confirmed the findings. Class III	A 078		
A 080 SS=D	429.52( ) FS; 59A-36.011(1) FAC Training - Core & Competency Test 429.52 (2) Administrators and other assisted living facility staff must meet minimum training and education requirements established by the agency by rule. This training and education is intended to assist facilities to appropriately respond to the needs of residents, to maintain resident care and facility standards, and to meet licensure requirements. (3) The agency, in conjunction with providers, shall develop core training requirements for administrators consisting of core training learning objectives, a competency test, and a minimum required score to indicate successful passage of the core competency test. The required core competency test must cover at least the following topics: (a) State law and rules relating to assisted living facilities. (b) Resident rights and identifying and reporting , neglect, and . (c) Special needs of elderly persons, persons with mental illness, and persons with and how to meet those needs. (d) Nutrition and food service, including acceptable sanitation practices for preparing, storing, and serving food. (e) Medication management, recordkeeping, and proper techniques for assisting residents with self-administered medication. (f) Firesafety requirements, including fire	A 080		

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A 080	Continued From page 3 evacuation drill procedures and other emergency procedures. (g) Care of persons with [illegible]'s [illegible] and related [illegible]. 59A-36.011 (1) ASSISTED LIVING FACILITY CORE TRAINING REQUIREMENTS AND COMPETENCY TEST. (a) The assisted living facility core training requirements established by the department pursuant to section 429.52, F.S., shall consist of a minimum of 26 hours of training plus a competency test. (b) Administrators and managers must successfully complete the assisted living facility core training requirements within 3 months from the date of becoming a facility administrator or manager. Successful completion of the core training requirements includes passing the competency test. The minimum passing score for the competency test is 75%. Administrators who have attended core training prior to [illegible], and managers who attended the core training program prior to [illegible], shall not be required to take the competency test. Administrators licensed as nursing home administrators in accordance with chapter 468, part II, F.S., are exempt from this requirement. (c) Administrators and managers shall participate in 12 hours of continuing education in topics related to assisted living every 2 years. (d) A newly hired administrator or manager who has successfully completed the assisted living facility core training and continuing education requirements, shall not be required to retake the core training. An administrator or manager who has successfully completed the core training but has not maintained the continuing education	A 080		

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A 080	Continued From page 4 requirements will be considered a new administrator or manager for the purposes of the core training requirements and must: 1. Retake the assisted living facility core training; and, 2. Retake and pass the competency test. (e) The fees for the competency test shall not exceed $200.00. The payment for the competency test fee shall be remitted to the entity administering the test. A new fee is due each time the test is taken. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interview, the administrator failed to complete the required 12 hours of continuing education in topics related to assisted living every 2 years. Findings: In a personnel record review of the Administrator, it revealed a hire date of . It confirmed the administrator passed the Core and competency test on . There was no evidence the administrator completed the required 12 hours of continuing education every two years. On at 11 AM, an interview with the Business Office Manager. She stated she could not find any documentation for the 12 hours of continuing education for the Administrator. Class III	A 080		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service	A 081		

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A 081	Continued From page 5 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee ' s personnel record. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011	A 081		

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A 081	Continued From page 6 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service	A 081		

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A 081	Continued From page 7 training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident . . . . ., neglect, and , . The facility must use its . . . . prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the	A 081		

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A 081	Continued From page 8 implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interview, the facility failed to ensure 2 of 7 sampled staff (A & B) received or had a completed certificate for 2-hour in-service training within 30 days of employment that covered elopement response, reporting adverse incidents, resident rights, resident behavior and needs, food handling practices, recognizing and reporting resident , neglect, and , and control. Findings: 1. A review of Unlicensed caregiver A's personnel record revealed a hire date of . The documentation showed incomplete certificates for the required trainings to include control and elopement response. 2. A review of Unlicensed caregiver B's personnel record revealed a hire date of . There was no documented evidence of the required trainings within 30 days of hire to include elopement response, reporting adverse incidents, resident rights, resident behavior and needs, food handling practices, recognizing and reporting resident , neglect, and On at 11 AM, an interview with the Business Office Manager confirmed the above	A 081		

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A 081	Continued From page 9 findings. (photographic evidence obtained) Class III	A 081		
A 082 SS=D	59A-36.011(4) FAC Training - / (4) / (/). Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on and , including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interview, the facility failed to ensure 1 of 7 sampled staff (B) received the required training in / (/) within 30 days of employment. Findings: In a personnel record review of Unlicensed caregiver B, it revealed a hire date of . There was no evidence of documentation of the required 1-hour / training was completed. On at 11 AM, an interview with the	A 082		

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A 082	Continued From page 10 Business Office Manager confirmed the findings. Class III	A 082		
A 090 SS=D	59A-36.011(11) FAC Training - . . . . . . (11) . . . . . TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding . (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding . . within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interview, the facility failed to ensure 2 of 7 sampled staff (A & B) received or had a completed certificate for the one-hour training in the facility's policies and procedures regarding . . . . . . ( ). Findings: 1. A review of Unlicensed caregiver A's personnel record revealed a hire date of . . . . . . The certificate was incomplete for the required 1-hour training in . . . 2. A review of Unlicensed caregiver B's	A 090		

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A 090	Continued From page 11 personnel record revealed a hire date of . There was no evidence of documentation for the required 1-hour training in . On at 11 AM, an interview with the Business Office Manager confirmed the above findings. (photographic evidence obtained) Class III	A 090		
A 161 SS=D	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by	A 161		

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A 161	Continued From page 12 Rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section 429.174, F.S., and Rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity ⌄ to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by Rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interview, the facility failed to ensure 1 of 7 staff (A) maintained a copy of the job description in the record. Findings: A personnel record review of Unlicensed caregiver A revealed a hire date of . There	A 161		

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A 161	Continued From page 13 was no documentation of the job description in the record. On at 11 AM, an interview with the Business Office Manager confirmed the findings. Class	A 161		
CZ875 SS=D	430.5025(4 &) / ; Training (4) Employees of covered providers must complete the following training for 's and related forms of ; (a) Upon beginning employment, each employee must receive basic written information about interacting with persons who have 's or related forms of . (b) Within 30 days after beginning employment, each employee who provides personal care to or has regular contact with participants, patients, or residents must complete a 1-hour training program provided by the department. 1. The department shall provide training that is available online at no cost. The 1-hour training program shall contain information on understanding the basics about the most common forms of , how to identify the signs and symptoms of , and skills for communicating and interacting with persons with 's or related forms of . A record of the completion of the training program must be made available to the covered provider which identifies the training curricula, the name of the employee, and the date of completion. 2. A covered provider must maintain a record of the employee's completion of the training program and, upon written request of the	CZ875		

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CZ875	Continued From page 14 employee, provide the employee with a copy of the record of completion consistent with the employer's written policies. 3. An employee who has completed the training required in this subsection is not required to repeat the program upon changing employment to a different covered provider. (c) Within 7 months after beginning employment for a home health agency, nurse registry, or companion or homemaker service provider, each employee who provides personal care must complete 2 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person ' s independence in activities of daily living, and skills in working with families and caregivers. (d) Within 7 months after beginning employment for a nursing home, an assisted living facility, an adult family-care home, or an adult day care center, each employee who provides personal care must complete 3 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, skills in working with families and caregivers, group and individual activities, maintaining an appropriate environment, and ethical issues. (e) For an assisted living facility, adult family-care home, or adult day care center that advertises and provides, or is designated to provide, specialized care for persons with . . . 's or related forms of , in addition to the training specified in paragraphs (a) and (b), employees must receive the following training: 1. Within 3 months after beginning employment, each employee who provides personal care to or has regular contact with the residents or	CZ875		

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	AL11969874	A. BUILDING: _____ B. WING _____	07/31/2024

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CZ875	Continued From page 15 participants must complete the additional 3 hours of training as provided in paragraph (d). 2. Within 6 months after beginning employment, each employee who provides personal care must complete an additional 4 hours of -specific training. Such training must include, but is not limited to, understanding and related forms of , the stages of 's , communication strategies, medical information, and stress management. 3. Thereafter, each employee who provides personal care must participate in at least 4 hours of continuing education each calendar year through contact hours, on-the-job training, or electronic learning . For this subparagraph, the term "on-the-job training" means a form of direct coaching in which a facility administrator or his or her designee instructs an employee who provides personal care with guidance, support, or -on experience to help develop and refine the employee's skills for caring for a person with 's or a related form of . The continuing education must cover at least one of the topics included in the -specific training in which the employee has not received previous training in the previous calendar year. The continuing education may be fulfilled and documented in a minimum of one quarter-hour increments through on-the-job training of the employee by a facility administrator or his or her designee or by an electronic learning , chosen by the facility administrator. On-the-job training may not account for more than 2 hours of continuing education each calendar year. (f)1. An employee provided, assigned, or referred by a health care services pool must complete the training required in paragraph (c), paragraph (d),	CZ875		

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CZ875	Continued From page 16 or paragraph (e) that is applicable to the covered provider and the position in which the employee will be working. The documentation verifying the completed training and continuing education of the employee, if applicable, must be provided to the covered provider upon request. 2. A health care services pool must verify and maintain documentation as required under s. 400.980(5) before providing, assigning, or referring an employee to a covered provider. (7) For a certified nursing assistant as defined in s. 464.201, training hours completed as required under this section may count toward the total hours of training required to maintain certification as a nursing assistant. (8) For a health care practitioner as defined in s. 456.001, training hours completed as required under this section may count toward the total hours of continuing education required by that practitioner's licensing board. (9) Each person employed, ... , or referred to provide services before , , , must complete the training required in this section before , , ... Proof of completion of equivalent training completed before . . , ... , shall substitute for the training required in subsection (4). Each person employed, , or referred to provide services on or after . . , ... , may complete training using approved curriculum under paragraph (5)(d) until the effective date of the rules adopted by the department under subsection (6). This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interview, the facility failed to ensure 1 of 7 sampled staff (A) completed the required 1-hour training.	CZ875		

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CZ875	Continued From page 17 Findings: A personnel record review of Unlicensed caregiver A revealed a hire date of . There was no documented evidence of the required 1-hour training. On at 11 AM, an interview with the Business Office Manager confirmed the findings. Class III	CZ875		
A 000	Initial Comments A complaint investigation #2024007114 and generator monitoring was conducted at Providence Living at Maitland on - . The facility had deficiencies at the time of the survey.	A 000		
A 010 SS=D	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of	A 010		

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A 010	Continued From page 18 appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . . . . . . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended	A 010		

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A 010	Continued From page 19 congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued	A 010		

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A 010	Continued From page 20 residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a , may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of	A 010		

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A 010	Continued From page 21 placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record reviews, and interviews, the facility failed to obtain a new AHCA Form, 1823 Health Assessment completed by the healthcare provider for continued residency for 1 of 9 sampled residents (#1) as required in an assisted living facility (ALF). Findings: On [redacted] at approximately 12:20 AM, a record review of Resident #1 revealed an admission date on [redacted]. The current 1823 Health Assessment Form dated [redacted] did not identify the resident as an elopement risk. Further review of Resident #1's record revealed an original admission 1823 Health Assessment Form dated [redacted] identified the resident as an elopement risk. Resident #1 was observed sitting in the common area dining room. Resident #1 was asked if she was wearing any jewelry or an ID bracelet with	A 010		

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A 010	Continued From page 22 her name, facility name, and address on her or ankles. On at 3:30 PM, Resident #1 pulled up both sleeves of her blouse to show she had no bracelet on her . Observation of her ankles did not reveal any ID bracelets as well. Resident #1 stated, "no one has put anything on me, and I don't wear any bracelets." The Administrator was asked for documentation to show daily efforts were made for Resident #1. On at 4:13 PM, the Administrator stated, "I will have to go and get it." The Administrator returned to the conference stating, "Resident #1 is not an elopement risk. We do not have any documentation." The Administrator was informed Resident #1's admission 1823 Health Assessment identified her as an elopement risk. The Administrator stated, "oh ok, we need to get a new 1823." The facility's undated Elopement Policy states, "Executive Director along with the DOW will if applicable resident identification will be placed with resident to include but limited to resident name, facility name, address, and phone number if resident is identified at risk for future elopement." (photographic evidence obtained) Class III	A 010		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26	A 025		

Agency for Health Care Administration

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A 025	Continued From page 23 (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 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	A 025		

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A 025	Continued From page 24 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 resident record review and interview, the facility failed to document written progress notes for significant changes for 2 of 9 sampled residents (#14 & #17) as required. Findings: 1. An incident was reported to the agency on [redacted] at 8:30 PM, Resident #14 [redacted] and found on the floor in her room with [redacted] coming from the right side of the [redacted]. 911 was called and Resident #14 was transported to the hospital and returned to the facility on [redacted] at 5:53 PM resulted a [redacted] hematoma. Resident #14's record review revealed an admission date of [redacted]. The last 1823 Health Assessment dated [redacted] listed medical history of [redacted]; Advance [redacted] and [redacted] disturbances, [redacted] and a [redacted] risk. She was recently admitted on Hospice care on	A 025		

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A 025	Continued From page 25 . She needs assistance with activities of daily living (ADLs) with ambulation, eating and transferring. Total care with bathing, , toileting and grooming. She needs assistance with self-administration of medications. She uses wheelchair for ambulation. A review of the facility's incident report dated at 8:30 PM, revealed Resident #14 in her room with injury resulting on left side of the and transferred to the hospital. There was no documented evidence of this written in the facility progress notes. 2. Resident #17 was identified COVID positive on . Resident #17's record review revealed qn admission date of . The last 1823 Health Assessment dated listed medical history of , Memory Loss, , Gait instability, , pre- and . She needs assistance with all activities of daily living (ADLs) specifically with showers ambulating with a cane or walker. She needs self-administration of medications. There was no documented evidence written in the facility progress notes for COVID. (Photographic Evidence Obtained) On at 11:35 AM, an interview with the Area Director of Wellness (ADW) confirmed the findings. Class III	A 025		

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A 032	Continued From page 26	A 032		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the	A 032		

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A 032	Continued From page 27 resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to make a daily effort to ensure 1 of 2 sampled residents who was identified as being at risk for elopement had identification (ID) on their person that included their name and the facility's name, address, and telephone number (#1 & #15) and The facility failed to have documentation that 1 of 7 sampled staff participated in a minimum of two resident elopement drills each year (D). Findings: Resident #15's record review revealed admission	A 032		

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PROVIDENCE LIVING AT MAITLAND	701 N MAITLAND AVE MAITLAND, FL 32751

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A 032	Continued From page 28 date . . . . The 1823 Health Assessment dated listed medical history of , , Memory Loss and . Her status was and forgetful. She was identified as an elopement risk. She is independent with all activities of daily living (ADLs) and often need redirection and a risk. She needs assistance with self-administration of medications. There was no elopement risk identification bracelet with the name of resident, name of facility with address and telephone number on Resident #15 and there was no documentation that the facility was making a daily effort checking for the identification bracelet was on her person or vicinity. Furthermore, a review of the & e-Mar Summary did not indicate daily checks documented. 3. On . . . . . Review of personnel records revealed Unlicensed caregiver D was hired on . . . . . . Review of the . . . . . and . . . . . resident elopement drills, the only two provided, revealed no documentation that the caregiver participated. On . . . . . at 11:50 AM, the Business Office Manager stated, Unlicensed caregiver D transferred from Ambiance at Maitland our other facility. The facility's undated Elopement Policy states, "The community will conduct four (4) Elopement Drills per year (1 drill per quarter). Staff on duty will participate in the drills. Direct care staff and the administrator will participate in 2 drills at a minimum. All drills will be documented."	A 032		

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A 032	Continued From page 29 The Business Office Manager (BOM) was informed that staff training for elopement drills and facility policies are facility specific and must be conducted for each location. On at 11:20 AM, an interview with the Area Director of Wellness (ADW) confirmed the finding. (Photographic Evidence Obtained) Class III	A 032		
A 036 SS=G	59A-36.007(10) CONTROL PROCEDURES (10) CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of (a) The facility must implement a hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or , hygiene may include the use of -based rubs, , handwash, or handwashing with soap and water. (b) Standard precautions must be used when there is an , exposure to transmissible agents in , , , nonintact skin, and mucuous during the provision of personal services. Standard precautions include: hygiene, and dependent upon the exposure, use of gloves, gown, mask, , protection, or a shield. (c) The facility must clean and reusable medical equipment and communal assistive	A 036		

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A 036	Continued From page 30 devices that have been designed for use by multiple residents before and after each use according to the manufacturer's recommendations. This Statute or Rule is not met as evidenced by: Based on observation, resident record review and interview, the facility failed to implement control for COVID and did not take appropriate precautions, hygiene program including sanitizing and cleaning, providing proper protective medical equipment (PPE) required to reduce risk of transmission and exposure; and the facility failed to report the transmissible agent to the local Department of Health (DOH) to request recommendations as required for 3 of 9 sampled residents (#15, #16, #17). Findings: An observation on . . . . . at 9 AM, some staff, not all staff were wearing N95 mask for COVID. There was no signage on the front door entrance informing visitors that the facility had positive COVID cases and to wear a mask. The signage was placed on the front desk, very hard for visitors to see and read. The front desk concierge did not inform the Agency for Health Care Administration (AHCA) surveyors that there was positive COVID cases at arrival into the facility. The front desk concierge was not wearing a mask. Once the Area Director of Wellness (ADW) not wearing a mask arrived at the facility at 9:45 AM, it was confirmed that there were 4 residents positive with COVID currently. In further observation later during tour at 10:30 AM, residents were congregating & mingling with each other in the common activity living room areas and hallways, *no* social distancing with	A 036		

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A 036	Continued From page 31 staff, visitors not wearing mask on both 1st and 2nd floor. There was no observation of housekeeping staff wiping and sanitizing all surfaces due to the current COVID outbreak. Near 1st floor [redacted]-138 residents observed mingling together and these residents were all identified as COVID positive currently that are listed below: 1. Resident #15 resides in [redacted] had signage on the door but no protective medical equipment (PPE) stored outside her room. Resident #15's first signs and symptoms for COVID on [redacted]. Resident #15's record review revealed admission date [redacted]. The 1823 Health Assessment dated [redacted] listed medical history of [redacted], Memory Loss and [redacted]. Her [redacted] status was [redacted] and forgetful. She was identified as an elopement risk. She independent with all activities of daily living (ADLs) and often need redirection and a [redacted] risk. She needs assistance with self-administration of medications. 2. Resident #16 resides in [redacted] A had signage on the door, but no protective medical equipment (PPE) stored outside his room. Resident #16's first signs and symptoms for COVID on [redacted]. Resident #16's record review revealed admission date [redacted]. The last 1823 Health Assessment dated [redacted] listed medical history of [redacted] type 2, [redacted], Myelodysplastic [redacted], Hyponatremia, Early [redacted] and Sundowner [redacted]. She was	A 036		

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A 036	Continued From page 32 with limited short-term memory. She need supervision with activities of daily living (ADLs) in bathing, , eating and grooming. Independent with ambulation, toileting and transferring. She needs assistance with self-administration of medications. 3. Resident #17 resides in had no signage on the door and no protective medical equipment (PPE) stored outside her room. Resident #17's first signs and symptoms for COVID on . Resident #17's record review revealed admission date . The last 1823 Health Assessment dated listed medical history of , , , , , , Memory Loss, , Gait instability, , , , pre- and . She needs assistance with all activities of daily living (ADLs), specifically with showers ambulating with a cane or walker. She needs self-administration of medications. On at 1:30 PM, an interview with both the Area Director of Wellness (ADW) and the Administrator detailing all the concerns & importance regarding the COVID outbreak in the facility and failing to follow their own control protocols including policies and procedures to prevent spread of COVID after revealing there was a COVID outbreak on and another COVID outbreak on (one month later). The first time the facility reported COVID to the Department of Health (DOH) was via email on for the second COVID outbreak on . The facility never reported to the Department of Health (DOH) for the first COVID outbreak on	A 036		

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A 036	Continued From page 33 . . . . The ADW stated that she did not have access to the DOH portal to report the first outbreak and that the DOH inspector was on vacation and did not follow up. A review of the facility's control policies and procedures dated . . . . . , revised on . . . . (recently) documented the purpose to control . . . . . by treating and handling all human , human components, products made from human . . . . , and other potential . . . . . material as if they are known to be . . . . for , . . . , COVID-19 (Corona), and other bloodborne , . . The policy listed the following: Item #4 of procedures for COVID-19 documented to follow the employer's related guidelines on COVID-19 during a pandemic, or when sounded statewide or nationally to implement universal precautions. a. wash . . . with . . . . . soaps. b. cover . . with a mask (N95, surgical, other acceptable . . . coverings). c. maintains a minimum of 6 social distancing. d. utilizes body and covering when needed, example: gowns, ... Item #5 practicing universal precautions for control for COVID-19. b. washing in accordance with the employer's guidelines on . . . Washing. i. wash before assisting with food and care for 20 seconds. ii. during care, when needed or between residents. iii. after care.	A 036		

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A 036	Continued From page 34 c. using personal protective equipment (PPE) according to the employer's guidelines. i. only uses for one person and change when needed. ii. only wear per manufacturers guidelines. d. cleaning contaminated surfaces in accordance employer's guidelines for . . . and Body Spills i. use bleach with a cloth material. ii. use bleach wipes. The facility did not have the proper . . . . . , and bleach to wipe surfaces. e. handling and disposing of contaminated materials in accordance with employer's guidelines. i. Sharp objects-use hard pore less containers. ii. Laundry-always use detergents and bleach or bleach products to remove . . . . . and stains. The facility did not have any red biohazard containers to dispose the contaminated PPEs. The facility's control policies and procedures did not document any protocol regarding isolation, room meal delivery, documenting testing during signs and symptoms and testing after isolation (no written number of days) to ensure COVID was resolved. The facility provided an incomplete line-item list of all COVID positive residents that did not detail isolation dates, 2nd testing to ensure that the first outbreak on was resolved before the second outbreak on . . . . . . The Administrator manually wrote the dates on during the complaint investigation visit.	A 036		

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A 036	Continued From page 35 The email from DOH dated responding to a request the Area Director of Wellness (ADW) regarding the 2nd COVID outbreak that begun on (last week). On this email was 2 staff and 17 positive residents that was positive for COVID-19. The Department of Health (DOH) requested the facility to report on the DOH portal link LTCFReporting@flhealth.gov and provided best practices after you enter line items of positive COVID residents and staff into the DOH portal. After, should do a 10-day isolation with day 0 being the date of symptoms onset or , test date. If the staff is identified as a healthcare worker, they should also do a 10-day isolation though discussion of the earlier return dates if: a. the staff test negative on Day 5 and Day 7, they can return on Day 7 or. b. if staffing presents an issue, they can return on Day 6, without testing if they are and wear a well-fitting higher quality mask like N95. There was no additional information provided regarding to PPE and outbreak testing protocol in this email. As to date , the facility failed to follow the Department of Health (DOH) above best practices and update in the DOH portal, and still failed to follow the DOH best practices and update on the DOH portal on . On at 10 AM, an interview with the Administrator who stated she was waiting to hear from the DOH with additional guidelines and recommendations for the COVID outbreak. The Administrator confirmed at 12 PM that she had not received any email response from the	A 036		

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A 036	Continued From page 36 county and/or CDC. On . . . . . at 4:10 PM, a telephone interview with the Department of Health (DOH) outbreak coordinator confirmed that the facility has not faxed over their line-item list and rescheduled her facility visit to next Wednesday, ... at 10 AM. The DOH coordinator stated her voice message informed callers she was out of the office, provided information for the DOH portal for reporting, and a follow up point of contact. The DOH coordinator stated the facility did not report on the DOH portal link LTCFReporting@flhealth.gov from the first outbreak nor did they follow up with her out of office point of contact. (Photographic Evidence Obtained) Class II	A 036		