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
	AL11969717	A. BUILDING: _____ B. WING _____	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEACOAST AT UPTOWN OAKS	12250 N 22ND STREET TAMPA, FL 33612

(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
CZ816 SS=D	408.809(2) 435.05(2) 59A-35.090(2d-3b) Background Screening-Compliance Attestation 408.809 Background screening; prohibited offenses.- (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's [illegible] to the Federal Bureau of Investigation for a national criminal history record check unless the person's [illegible] are enrolled in the Federal Bureau of Investigation's national retained print [illegible] notification program. If the [illegible] of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit [illegible] electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the [illegible] to the Federal Bureau of Investigation for a national criminal history record check. The [illegible] shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print [illegible] notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person [illegible]. The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards	CZ816		

AHCA Form 3020-0001

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

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CZ816	Continued From page 1	CZ816		

submitted within the previous 5 years to meet any provider or professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that:
(a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section;
(b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and
(c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency.

435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers:
(2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if for any of the disqualifying offenses while employed by the employer.

59A-35.090 Background Screening.
(2) Processing Screening Requests, Required Documents and Fees.
(d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, , herein incorporated by reference, available at http://www.flrules.org/Gateway/reference.asp?No=

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CZ816	Continued From page 2 Ref-09106, and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Regulations_Forms.shtml . This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if for any disqualifying offense. (e) An administrator or chief financial officer must be screened and qualified prior to , , to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the report and court disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to Section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with Section 435.06(3), F.S. This Statute or Rule is not met as evidenced by: Based on staff record review and interview, the	CZ816		

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CZ816	Continued From page 3 facility failed to ensure that an Attestation of Compliance was signed every five years with background screening for one employee (Staff F) of two sampled employees. Findings Included: During a record review for Staff F conducted on , revealed that Staff F had not signed a Background Screening Attestation of Compliance, and it was not in his record. Staff F was hired on . During the interview with the Administrator conducted on at 12:17pm, the Administrator agreed that Staff F Background Screening Attestation of Compliance was not signed by the employee. Class III	CZ816		
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	CZ875		

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CZ875	Continued From page 4 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 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	CZ875		

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CZ875	Continued From page 5	CZ875		

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 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

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CZ875	Continued From page 6	CZ875		

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 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), 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.

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CZ875	Continued From page 7 456.001, 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 record review and interview the facility failed to ensure that one (Staff G) of two sampled employees hired after whose records were reviewed had the required 1 hour and Related (ADRD) training. Findings Included: During an employee record review conducted on revealed that Staff G who had a hire date of , did not have the required 1-hour ADRD training within 3 months of hire. During the interview with the Administrator conducted on at 12:17pm, the Administrator agreed that Staff G did not have the required training.	CZ875		

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CZ875	Continued From page 8 Class III	CZ875		
A 000	Initial Comments A complaint investigation (complaint number: 2024011438, 2024011512, 2024012212) was conducted at Seacoast at Uptown Oaks on . The facility had deficiencies at the time of the survey.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the 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	A 025		

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A 025	Continued From page 9 accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain resident written records with an update in the residents' condition for two Residents (#1 and #2) of two sampled residents that had a change in condition, a law enforcement investigation, an elopement, and/or an illness that resulted in medical attention.	A 025		

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A 025	Continued From page 10 Findings Included: A review of a self-reported document regarding Resident #1, conducted on , revealed that Resident #1 eloped from the secured memory care and the facility on . Resident #1 was located across the street from the facility. A review of resident #1's written record, conducted on , revealed that Resident #1's elopement from the facility was not documented in the resident's record. There was no evidence of intervention put in place to prevent Resident #1 from future elopements. A review of a self-reported document regarding Resident #2, conducted on , revealed that Resident #2 went missing when the facility's transportation driver dropped the resident off for a doctor's , , . Resident #2 did not make it to the scheduled doctor's , , and a law enforcement investigation ensued. During an interview with the Sales and Marketing Director, conducted on at 09:30am, the Sales and Marketing Director stated that Resident #2 was found four days later by a law enforcement officer and taken to a local hospital for evaluation and treatment. A review of resident #2's written record, conducted on , revealed that Resident #2's law enforcement investigation was not documented in the resident's written record. During an interview with the Administrator, conducted on at 01:53pm, the	A 025		

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A 025	Continued From page 11 Administrator agreed that there was no documentation in Resident #1 and #2's written record regarding their changes, in condition MC and Resident #2's RS records regarding their change in condition, law enforcement investigation, elopement, and/or illness that resulted in medical attention. Class III	A 025		
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	A 032		

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A 032	Continued From page 12 pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response 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:	A 032		

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A 032	Continued From page 13 Based on observation, record review, and interview, the facility failed to ensure that employees working with residents at risk for elopements and had previously eloped from the facility were able to identify residents at risk for elopement for three employees (Staff C, D, and E). Additionally, the facility failed to ensure that residents who were at risk for elopements had identification on the person that noted the resident's name and the facility's name, address, and telephone number for twenty-five residents who were at risk for elopements. Furthermore, the facility failed to ensure that their elopement policy and procedures noted how the facility would meet the continued care for all residents during an elopement response event. Finding Included: A review of a self-reported document regarding Resident #1, conducted on , revealed that Resident #1 eloped from the secured memory care and the facility on . Resident #1 was located across the street from the facility. A review of the list of residents who were at risk for elopement, conducted on , revealed that there were twenty-five residents on the list that were at risk for elopements. The twenty-five residents all resided in the facility's secured memory care unit. During an observation of twenty-five residents in the memory care unit, conducted on at 12:00pm, it was observed that none of the twenty-five residents had identification on the person.	A 032		

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A 032	Continued From page 14 A review of the undated elopement policy and procedures entitled 'Emergency Procedure - Missing Resident', conducted on , revealed that the facility's elopement policy and procedures did not include how the facility would meet the continued care for all residents during an elopement response event. During interviews with Staff C, D, and E, conducted on from 12:10pm through 12:28pm, Staff C, D, and E stated that there were no residents that were at risk for elopement residing in the memory care unit. Staff C, D, and E stated that none of the residents had identification on their person. Staff C, D, and E were unaware that Resident #1 had eloped on . During an interview with the Administrator, conducted on at 01:15pm, the Administrator agreed that the facility's policy and procedures did not include how the facility would meet the continued care for all residents during an elopement response event. Class III	A 032		
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	A 052		

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A 052	Continued From page 15	A 052		

prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers.
(b) In the presence of the resident, confirming 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

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A 052	Continued From page 16 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. (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	A 052		

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A 052	Continued From page 17 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 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	A 052		

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A 052	Continued From page 18 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 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 and interview, the facility failed to ensure proper assistance with self-administration of medications by not comparing the medication labels to the medication observation records (MORs); not advising residents of the names and doses of their medications; and, not popping or pouring medication from pill packs or bottles in front of residents for two Residents (#3 and #4) of two sampled residents. Findings Included: During an observation of the medication pass with Staff C (an unlicensed Medication Technician) for Residents #3 and #4, conducted on from 12:21pm through 12:26pm, Staff C assisted	A 052		

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A 052	Continued From page 19 Resident #3 and #4 with the residents' prescribed noon medications. Staff C placed the medication into a medication cup while at the medication cart and neither resident was present. Staff C did not have Resident #3 and #4's MORs open and Staff C did not compare the medication labels to the residents' MORs. Staff C did not orally advise the resident of the name and dose of the medication. During an interview with the Corporate Clinical Compliance and the Resident Care Coordinator, conducted on at 01:00pm, both agreed that unlicensed Medication Technicians were supposed to compare medication labels to MORs, read the name and dose of the medications from the medication labels to the residents, and pop or pour the medications from the medication containers in front of the residents. 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	A 081		

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A 081	Continued From page 20 personnel record. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility 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	A 081		

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A 081	Continued From page 21 facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident ,	A 081		

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A 081	Continued From page 22 neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that staff had the required two-hour pre-service orientation training for two (Staff F and Staff G) of the two sampled staff.	A 081		

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A 081	Continued From page 23 Findings included: A record review of Staff F, Transportation Driver's record conducted on revealed that Staff F who was hired on had no evidence of the required two-hour pre-service orientation training. A record review of Staff G, Medication Technician's record, conducted on revealed that Staff G who was hired on had no evidence of the required two-hour pre-service orientation training. During the interview with the Administrator conducted on at 12:17pm, the Administrator agreed that Staff F and Staff G did not have the required training. Class III	A 081		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own	A 152		

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A 152	Continued From page 24 belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be This Statute or Rule is not met as evidenced by: Based on observations, record review, and interview, the facility failed to maintain all existing mechanical and electrical systems in good working order and free of hazards for all residents in and surrounding the facility. Furthermore, the facility failed to maintain a safe, clean, and decent living environment (photographic evidence obtained). Findings Included:	A 152		

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A 152	Continued From page 25 During observations of the first, second, and third floor assisted living units, conducted on from 10:03am through 10:17am, it was observed that there was a strong odor of coming from Resident #10's . The carpet in Resident #6's rooms was dirty or stained. The paint was peeling from Resident #8 and 13's entry door to . Resident #7's carpet in was dirty or stained. There was a musty, mildew odor throughout the first, second, and third floor assisted living units. The thermostat outside the dining room was set on 70 degrees and it was 78 degrees in the area. There were two portable air condition window units in each dining room. The base board outside of Resident #9's had chunks of wood missing. It was observed during observations from 10:27am through 01:28pm, that the dining room entry tile had dried brown drips and smears throughout and there were four cracked and broken tile. The tile on the wall by the elevator had one cracked and broken tile. The baseboard in the first-floor restroom had an accumulation of dust caked onto the baseboard. The windows in the third-floor billiards room were extremely dirty and the view was obstructed. During observations of the second-floor memory care unit, conducted on from 10:18am through , there was an extreme odor of throughout the hallways in the memory care unit. There were three dining room chairs in the television area and two of the chair's seats were torn and one of the chair's seat had brown stains. The wall outside Resident #11's , the drywall was cracked and peeling. The hallway floor was not swept and had residue of unknown substance throughout. The drywall was cracked and peeling and there were black scuff marks	A 152		

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A 152	Continued From page 26 along the wall and entry door to Resident #12's . There were three medication carts that had drips, spills, and dust accumulation to the work surface and base skirt. During an interview with the Administrator, conducted on at 11:07am, was unable to provide evidence that the facility was ensuring that the inside temperatures did not rise above 81 degrees. The Administrator stated that the temperatures were checked weekly. A review of an air condition repair quote dated , revealed that this was a repair quote for one broken air condition unit. There were no other quotes provided. During an attempt to review the temperature check documents, conducted on , revealed that the temperature checks for and were exact photographic images of each other. There were no original temperature check documents provided. This temperature check documented noted that there were portable air condition units in , 308A, 308B, 313, 323A, 323B, 327B, 328A, 336A, 336B, two in the first-floor dining room, and two in the second-floor dining room. During an interview with Staff I, conducted on at 10:30am, Staff I stated that the facility has had air condition issues since before , and more rooms and areas are affected each day. Staff I stated that the facility relied a lot on the portable window air condition units because there something wrong with multiple central air condition systems and they just leave them broken.	A 152		

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SEACOAST AT UPTOWN OAKS	12250 N 22ND STREET TAMPA, FL 33612

(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 152	Continued From page 27 During an interview with the Administrator, conducted on at 11:07am, the Administrator was not able to state at what time of the day each of the temperature checks were obtained. After reviewing each physical environment photograph with the Administrator, the Administrator agreed that the facility needed housekeeping and repair work for dust accumulation, broken tile, wall dents, peeling drywall, scuffmarks, and dirty carpets, and dirty windows, baseboards, and medication carts. During an interview with Staff B, conducted on at 01:10pm, Staff B stated that the facility air condition systems started breaking down before , but could not state exactly when. During an interview with the Maintenance Director, conducted on at 01:10pm, the Maintenance Director stated that he was not aware of where all of the portable air condition units were located. The Maintenance Director stated that there were thirty to thirty-two portable air conditions in use but some of the units were in unoccupied rooms. Class III	A 152		