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
	AL11969590	A. BUILDING: _____ B. WING _____	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU MADELEINE	205 HARDOON LANE MELBOURNE, FL 32940

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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 ␣ , to the Federal Bureau of Investigation for a national criminal history record check unless the person's ␣ , are enrolled in the Federal Bureau of Investigation's national retained print notification program. If the ␣ , 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 ␣ , electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the ␣ , to the Federal Bureau of Investigation for a national criminal history record check. The ␣ , shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print 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 ␣ , . The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or	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 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 =Ref-09106, and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Service	CZ816		

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CZ816	Continued From page 2 s/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 personnel record reviews and interviews, the facility failed to ensure 2 of 10 sampled staff (N & P) completed an Attestation of Compliance with Background Screening Requirements.	CZ816		

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CZ816	Continued From page 3 Findings: A review of caregiver P's personnel record revealed a hire date of . The record did not have a completed Attestation of Compliance with Background Screening Requirements. On at 2:40 pm, the human resource manager said caregiver P did not complete the attestation. A review of caregiver N's personnel record revealed a hire date of . The record did not have a completed Attestation of Compliance with Background Screening Requirements. On at 1:12 pm, the human resource manager said caregiver N did not complete a signed Attestation of Compliance. Unclassified	CZ816		
CZ830 SS=D	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the	CZ830		

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CZ830	Continued From page 4 plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward	CZ830		

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CZ830	Continued From page 5 reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to submit their Comprehensive Emergency Management Plan (CEMP) to the Department of Emergency Management Annually. Findings: On at 12:19 pm, the Administrator was asked for the CEMP manual. He stated the	CZ830		

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CZ830	Continued From page 6 county had not sent him his approval letter. On at 12:20 pm, the Administrator explained he submitted the paperwork for the new CEMP, however the county had not accepted the forms. The administrator also stated he was told by the county representative that his CEMP was good until next year, , . On at 2:03 pm, the Administrator showed an email that revealed the CEMP was sent on . The renewal was rejected, as the Administrator had not followed the new guidelines set by the state agency. On at 2:33 pm, a telephone call was made to the county representative. The county representative stated the current CEMP expired as of . The county representative explained that on , he sent an email to the Administrator with the new guidelines for the agency as well as the county. The county representative said he would send the email correspondence. On at 4:01 pm, the Administrator stated he forgot to submit the CEMP in which was 60 days prior to the expiration date. The Administrator said he had a business to run and could not always keep up with everything. Photographic evidence obtained Unclassified	CZ830		
CZ875 SS=D	430.5025(4 &) / ; Training (4) Employees of covered providers must	CZ875		

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CZ875	Continued From page 7 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 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	CZ875		

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CZ875	Continued From page 8 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 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	CZ875		

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CZ875	Continued From page 9	CZ875		

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), 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

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CZ875	Continued From page 10 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 review and interview, the facility failed to ensure 4 of 8 sampled staff, (G, H, I, F) who provided personal care to residents with or Related forms of (ADRD) participated in at least 4 hours of continuing education each calendar year. Findings: On at 10:34 am, a secured memory care unit was seen inside the facility. 1. A review of caregiver F's personnel record revealed a hire date of . The record showed ADRD level 2 training on . 2. A review of nurse G's personnel record	CZ875		

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CZ875	Continued From page 11 revealed a hire date of . The record noted ADRD level 2 training on . 3. A review of caregiver H's personnel record revealed a hire date of . The record documented ADRD 1-hour of training on , 1-hour on and 2-hours on . 4. A review of nurse I's personnel record revealed a hire date of . The record read, ADRD level 2 training on . None of the personnel records had documentation to indicate they participated in at least 4 hours of continuing education each calendar year. On at 2:40 pm, the human resource manager said none of the staff participated in the required continuing education and she did not know they had to since the facility had only a secure parameter. On at 10:10 am, a review of Florida health finder website revealed the facility advertised that it provided memory care. Class III	CZ875		
A 000	Initial Comments Complaint survey #2024010067, generator monitoring, and Limited Nursing Services (LNS) monitoring were conducted on through . There were deficiencies identified at the time of the survey. Class I was identified for A0025, A0030, and A0077.	A 000		

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A 025	Continued From page 12	A 025		
A 025 SS=J	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making . . for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the 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.	A 025		

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A 025	Continued From page 13 (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 interviews, the facility failed to provide care and services appropriate to meet the needs of residents accepted to the facility by failing to provide daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical well-being of the resident for 1 of 15 residents sampled. (Residents #1) Findings: A review of resident #1 record revealed he was admitted on . His record contained a Resident Health Assessment form (1823) dated . The form documented he needed assistance with when admitted to the facility. A Care Plan signed by the Director of Nursing (DON) on documented resident	A 025		

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(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	Continued From page 14 #1 was independent with Activities of Daily Living (ADL's) and self-administered his medications. Resident #1 lived in a licensed Assisted Living (ALF) bed. A review of a facility note documented by nurse I on at 1:57pm - Housekeeper called to resident's room. This nurse was then called to the room. was initiated and 911 called. Paramedics and police arrived and pronounced . Son notified. On at 2:30pm caregiver E said in interview she worked on 7am-3pm shift. Staff J alerted her and caregiver H in person of resident #1 not looking good. They went to his room and found resident #1 in bed. Caregiver (E) described resident #1 as being and purple/black in color. They notified the Director of Nursing (DON) and Nurse I by walkie talkie. Caregiver E said this was around 10 or 11am. Caregiver E said she and caregiver H left when the nurses entered the room. Caregiver E said she did not start or see the nurse's doing . She said resident #1 was lying on his in the bed. There was a foul odor, but she thought it might be from the resident across the hall. caregiver E said resident #1 was self-sufficient with ADL's. The facility staff made his bed every morning. The resident ate in the dining room downstairs. A review of the call bell history report revealed on at 4:15am the pull cord in resident #1 bathroom was activated. A review of the call bell history report revealed the light was reset 2 hours and 10 minutes later. On at 9:35am an interview with the Administrator was conducted. He said he did not	A 025		

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A 025	Continued From page 15 conduct or document an internal investigation regarding resident #1. He said an officer arrived with the ambulance and did his own investigation. He also said residents die all the time in Assisted living. He did not think he needed to do an investigation. On at 10am an interview with caregiver H was conducted. She said she worked on 7am-3pm shift. She said staff J, the housekeeper, came to her in the 300 hallway and told her something was wrong with resident #1. She said when she entered the room, she saw resident #1 lying on his in his bed. His was . Both his were hanging off the bed. He was discolored black and purple and not breathing. She called for nurse I and the DON over the walkie talkie. She said her, Caregiver E, the DON, and nurse I were in resident #1's room. She described resident #1 as having , coming from his and running down his . Resident #1 normally was oriented and able to call if he needed assistance. The last time she remembered seeing him alive was on Thursday . She said she did not start when she first entered the room because she was so freaked out by the way he looked. After the paramedics left, the DON asked her and caregiver E to dress resident #1 before the family arrived. When an officer arrived, he asked them to stop, and he took pictures. She said she was aware there was a camera in the room. On at 10:35am an interview with staff J (housekeeper)was conducted. He said on Monday he went into resident #1's room between 12 and 1pm to collect the kitchen trash. He said the trash was collected every day. He also worked on Sunday and he collected the trash. He said on Sunday resident #1 was in	A 025		

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A 025	Continued From page 16	A 025		

bed and looked like he was asleep. On Monday while collecting the trash, he noticed a smell from the room and resident #1 had one off the bed. His was black. He did not touch the resident. He called for nursing over the radio then went into the hallway and notified caregiver H. He said he last saw the resident on Thursday .

On at 11:10am an interview with staff K (Human Resources) was conducted. She said she went to resident #1's room on because she heard Nurse I called for the DON on the walkie talkie. She said she was the closest because resident #1's room was right around the corner from her office. She said it was around lunch time. She said she did not go into the bedroom but saw resident #1 lying in bed under a cover. He had one out from under the covers and it was blue. Nurse I was coming out of the room saying she needed the DON. Caregiver E and H and staff J (housekeeper) were in the room. Staff K (Human resources) said she left the room to find the DON.

On at 11:28am an interview with staff M (dietary manager) was conducted. She said the servers take food orders from the residents and put them into the computer. Then, the kitchen staff can read them and prepare the food. The orders are kept for a year. The system only tracks orders and does not alert if residents miss meals.
A review of resident #1 food orders from - found resident #1's last meal in the dining room was at 1:38pm.

On at 1:23pm in an interview with the Administrator he confirmed every resident in the facility was assigned a call pendant when they

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A 025	Continued From page 17	A 025		

moved in. The staff are expected to answer the call bells regardless of the resident's level of care. He said an appropriate time frame would be minutes if it was his mother. He confirmed 2 hours and 10 minutes was an excessive amount of time for the call bell to be unanswered.

On at 3:50pm an interview with the DON was conducted. She said resident #1 was oriented and he was able to self-administer his medications. He lived in an ALF licensed bed. On she was called to resident #1 room by nurse I sometime before lunch. He was lying on his in bed. He looked and had one , hanging off the bed. She did not initiate . She left the room and went to the nurse's station on the second floor to notify the resident's family. She told the power of attorney he had no , or , . She then returned to resident #1 room on the 3rd floor and told nurse I to start . She did not bring the Automated External Defibrillator ( ) from the nurse's station. She said caregivers E and H were in the room. She did not recall who verified resident #1 code status. She did not call 911 and was not sure who did. The paramedics arrived and told them to stop . She described resident #1 as being bluish and he had some on his sheets. She said there had been no indication he was going to die. She confirmed she did not conduct any type in investigation concerning resident #1 . She confirmed the facility does not have a system to check if the ALF residents are okay daily. There are no standard resident checks performed by any staff. She said they do not have to do that. She did not know when he last had a meal in the dining room and did not check after his .

On at 5:29pm an interview with Nurse I

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A 025	Continued From page 18 was conducted. She said Caregivers E and H called her over the walkie talkie about resident #1. She went to his room and found the resident lying on his in bed. He was , purple, and he had , on his . He had no vital signs. Nurse I, the DON, caregivers E and H moved the resident from the bed to the floor using the sheets from the bed. The DON told her he was a full code and told her to start , . There was no in the room. She said she was made aware of a camera in the room after the resident passed. On at 5:48pm an interview with Registered Nurse G was conducted. She said she worked 11pm-7am from to . She turned off the bathroom call light the morning of in resident #1 room. Caregiver P was with her. She said the resident was lying in bed under the covers. They did not approach the bed because the resident appeared to be sleeping. Registered Nurse G did not assess resident #1. On at 10:20am an interview with the Administrator and the DON was conducted. The administrator said he was not aware of resident #1's call bell not being answered for more than 2 hours on . He said he did not go to the resident's room the day he . He also said he did not have a conversation with resident #1 son in the hallway outside resident #1 room the day he . He confirmed he did not do any type of investigation or interview any staff including the DON about resident #1. At 10:25am the DON said there had never been any other resident who was in the condition that resident #1 was in. On at 10:38am in an interview with staff T (housekeeper) he said he collected the kitchen trash from resident #1's room on around	A 025		

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A 025	Continued From page 19 1:55pm. The resident was sleeping in bed. He last saw resident #1 alive on . On at 11:40am in an interview with staff V (activity staff) she said resident #1 went on an outing to the grocery store with her on . She took pictures of him on the outing. She showed pictures of the residents including # 1, enjoying their outing. The photos were stamped . She said resident #1 did not go to her (JANGA) activities on Saturday because he was going to go to a different activity with other residents. On at 12:30pm an interview with caregiver Q was conducted. She said she worked on and 7am-3pm and 3pm-11pm. A double shift both days. She was familiar with resident #1. She did not provide any care for him except to make his bed. She could not remember if she made his bed or saw him at all that weekend. On at 2:41pm a second interview with Registered Nurse G was conducted. She said the security guard was the person who probably notified her of resident #1 call bell being activated. She did not have the portable phone. She said she had not been given one. She was not in the nurse's station where the monitors were to see the call lights. She was not aware of how long it had been on. She did respond to the bathroom call bell and turn it off. She saw resident #1 from the bathroom door and he appeared to be sleeping so she did not go to the bed to assess him. She said the bed was about 10 to 15 from the bathroom door. She did not remember if the light was on in the room. She was not aware there was a camera in the room.	A 025		

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A 025	Continued From page 20 On at 9:10 am, night concierge S said his shift was 11 pm to 7 am. He said his tasks included watching the cameras at the front desk and conducting safety security rounds, mainly outside. He said he carried a portable radio. He said a phone at the front desk beeps if either a pendant is pushed, or a pull cord is activated. He said it beeps until they are manually reset. He said if the nurse on duty does not answer the call within 30 to 45 seconds, he calls the room number over the radio. He did not remember calling nurse G over the radio on to respond to resident #1's call light. When he was told the nurse reported she learned from him that the call light was on, he said maybe the nurse was outside smoking and he did call her on the radio. On at 11am in an interview with caregiver H she said on there were 4 facility staff in resident #1 room. She entered the room first. Caregiver E, nurse I and the DON arrived after. She said it took about 5 minutes for everyone to arrive. She confirmed none of the responding staff started when they arrived. Within about 5 minutes they put resident #1 on the floor using the bed sheets. She said the DON told nurse I she had to do until the paramedics arrive. The paramedics would tell them to stop. She said the Paramedics told nurse I to stop when they entered the room. They did not hook up any machines to him or continue . She confirmed she was assigned to resident #1 area but had not checked on him that day. She said the whole 3rd floor had a bad odor. On at 9:10am an interview with resident #1's son was conducted. He said on he received a call from the DON. She said his father	A 025		

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A 025	Continued From page 21 was found unresponsive and was being performed. After his father's he reviewed the video from the camera in his father's room while waiting in the facility to see his father before going to the funeral home. He said: on Saturday his father pulled his bathroom call light at around 4:14am. He is then seen walking with his walker with a trash can on it to his bed. The light was on in his room because he was waiting for assistance. 2 nurses come in (names unknown) at change of shift about 6:30am on . He said the staff turned off the call bell and never acknowledged his father or checked on him. The staff should have been aware of the call bell since they use telephones which receive alerts when the call bells are used. When he checked the video, he found that on the DON could be heard on the video saying let me know when the ambulance gets here and something about not having lawsuits. Resident #1 was moved to the floor and started when the paramedics entered the facility. He said no autopsy was performed because the father of the Administrator and owner of the facility, signed the certificate and waved the autopsy. The detectives got his father's , from the funeral home and had it checked. They found that his father's stopped about ½ hour after he pulled the emergency bathroom cord. He said his father missed several meals and activities and still no one checked on him. He said he has pictures of his father and the bed which was stained with due to decomposition. The A/C was not on because his dad was usually . He said he had a conversation with the administrator in the hallway outside of his father's room on . He told him he was shocked to learn his dad was left for	A 025		

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A 025	Continued From page 22 a couple of days and not checked on. Upset about the condition his father's body was in. He was upset because his father was not checked on for days. He said he was a little loud because he was upset. He confirmed his father did not have a . He wanted to live every minute of life. A review of an internal interrogation performed on for resident #1 , Defibrillator ( ) documented on an Episode List, the device identified on at 4:41am. The line is identified with an arrow and flat lined is written next to the line. (Photographic Evidence Obtained) Class I	A 025		
A 030 SS=J	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility	A 030		

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A 030	Continued From page 23 policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and . ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own	A 030		

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A 030	Continued From page 24 sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and	A 030		

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A 030	Continued From page 25 visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or	A 030		

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A 030	Continued From page 26 termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the	A 030		

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(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 030	Continued From page 27 State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe	A 030		

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	AL11969590	A. BUILDING: _____ B. WING _____	09/20/2024

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A 030	Continued From page 28 management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to honor resident's right to live in a safe and decent living environment free from neglect by not ensuring staff respond to emergency call lights in a timely manner and failed to honor resident's right to receive timely , , ( ) for 1 of 15 residents sampled. (Resident #1). Findings: A review of resident #1 record revealed he was admitted on . Record contained a Resident Health Assessment form (1823) dated noting resident was alert and oriented and did not require assistance with his activities of daily living (ADL's). Resident #1 lived in a licensed Assisted Living Facility (ALF) bed. A review of the call bell history report revealed on at 4:15 am the emergency pull cord call bell was activated in resident #1's bathroom. Continued review of the call bell history report revealed the light was not reset until 2 hours and 10 minutes later. On at 11:15 am the Automated External Defibrillator ( ) was observed on the second floor in the nurse's office. A sign indicating the location of the was posted outside the office door. Continued observations noted the pads would not expire until and the battery would not expire until . The was tested at this time and found to be ready for use.	A 030		

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A 030	Continued From page 29 While in the nurse's office the resident files were also observed in 3 ring binders on shelves on the wall with large ( ) stickers noted on the , of some of the resident files. On at 11:28 am an interview was conducted with dietary staff M. She provided a food order summary and said the system only tracks orders and does not alert if residents miss meals. Review of resident #1 food orders from - found resident #1's last meal in the dining room documented on at 1:38 pm. On at 1:23 pm in an interview with the Administrator he confirmed every resident in the facility was assigned a call bell pendant when they moved in and stated staff are expected to answer the call bells regardless of the residents' level of care. He said an appropriate time frame to answer call bells would be minutes if it was his mother. He confirmed 2 hours and 10 minutes was an excessive amount of time for resident #1's call bell to be on without answering it. A request was made to review the facility call bell policy. The Administrator was unable to provide one stating they do not have a call bell policy. On at 5:48 pm an interview with Registered Nurse G was conducted. She stated she worked 11 pm - 7 am on and . She turned off the bathroom call light the morning of in resident #1's room and stated Caregiver P was with her. She said the resident was lying in bed under the covers and they did not approach the bed because the resident appeared to be sleeping. Registered Nurse G did not assess resident #1 at that time.	A 030		

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A 030	Continued From page 30 On at 3:50 pm an interview with the DON (Director of Nursing) was conducted. She said on she was called to resident #1's room by nurse I sometime before lunch. He was lying on his in bed and looked to be and had one hanging off the bed. The DON left the room and went to the nurse's station on the second floor to notify the resident's family. She told the resident's son he had no , or and then she returned to resident #1's room on the 3rd floor and told nurse I to start . The DON did not bring the Automated External Defibrillator ( ) with her from the nurse's station. She said caregivers E and H were in the room but she did not recall who verified resident #1's code status. The DON stated she did not call 911 and was not sure who did. However, paramedics arrived and told them to stop . Continued interview with the DON confirmed the facility does not have a system in place to check if ALF residents are okay on a daily basis and there were no standard resident checks performed by staff. On at 10:25 am interview with the DON said she had never seen any other resident die in the facility who was in the condition that resident #1 was in when he was found. On at 12:30 pm an interview with caregiver Q was conducted. She said she worked on and 7AM - 3 pm and 3 pm - 11PM, a double shift both days. She was familiar with resident #1 and stated she did not provide any routine care for him except to make his bed but could not remember if she made his bed or saw him at all that weekend. On at 2:41 pm a second interview with Registered Nurse G was conducted. She said	A 030		

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A 030	Continued From page 31 the security guard was the person who probably notified her of resident #1's call bell being activated as she did not have a portable phone, stating she had not been given one yet. She was not in the nurse's station where the monitors are located that display where activated call lights are. She stated was not aware of how long the light had been on, but responded to the bathroom call bell early Saturday morning on and turned it off. She saw resident #1 from the bathroom door and he appeared to be sleeping so she did not go to the bed to assess him. She said the bed was about 10 to 15 from the bathroom door. She did not remember if the light was on in the room and stated she was not aware there was a camera in the room. On at 11 am in an interview with staff H she said on there were 4 facility staff in resident #1's room. She entered the room first. Caregiver E, nurse I, and the DON arrived afterwards. She said it took about 5 minutes for everyone to arrive. She confirmed none of the responding staff started when they first arrived and there was no brought to the room by any of the responding staff. Within about 5 minutes they put resident #1 on the floor using the bed sheets. She said the DON told nurse I she had to do until the paramedics arrived and they tell them to stop. She continued to say upon Paramedics arrival to the room they told nurse I to stop . The paramedics did not hook up any machines to resident #1 or continue . She confirmed she had not checked on resident #1 that day and also said the whole 3rd floor had a bad odor. (Photographic Evidence Obtained)	A 030		

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A 030	Continued From page 32 Class I	A 030		
A 077 SS=J	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all	A 077		

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A 077	Continued From page 33 residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least , ; 2. If employed on or after , have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to , , are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if	A 077		

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A 077	Continued From page 34 the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393.	A 077		

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A 077	Continued From page 35 This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility's Administrator failed to supervise and maintain management of all staff and ensure provision of appropriate care and services to meet the needs of all residents when staff did not provide adequate supervision and monitoring of the general health, safety, and physical wellbeing for 1 of 10 sampled residents, (#1). Findings: Review of resident #1's record noted he was admitted on and discharged on . Review of resident #1's Assisted Living Facility (ALF) contract revealed it was signed by resident's Power of Attorney (POA) on . The contract referenced exhibit B of the resident handbook, which documented residents' trash would be taken out every morning and their bed was to be made every morning by facility staff. A review of the call bell history report revealed on at 4:15 am, the emergency pull cord call light was activated in resident #1's bathroom. Continued review of the call bell history report revealed the light was not reset until 2 hours and 10 minutes later. Review of a facility note documented by nurse I on at 1:57 pm noted the Housekeeper, after going into resident #1's room, called for caregivers to come into resident's room. Afterwards, Nurse I was called to the room, was initiated and 911 called. Paramedics and police arrived and resident #1 was pronounced	A 077		

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A 077	Continued From page 36 On at 5:12 pm, review of a note read the funeral home picked up resident #1 with POA present at the time of pickup. On at 2:30 pm caregiver E said she worked on on the 7 am - 3 pm shift. She said Staff J alerted her and caregiver H that resident #1 did not look good. She continued stating they went to his room and found resident #1 in bed. Caregiver E described resident #1 as being and purple/black in color. She said they notified the Director of Nursing (DON) and Nurse I by walkie talkie. Caregiver E said this was around 10 or 11 am stating she did not start or see the nurses doing at that time. She recalled there was a foul odor, but she thought it might be from the resident across the hall. On at 10 am, staff H said when she entered resident #1's room, she saw the resident lying on his in his bed. His was and both his were hanging off the bed. She remembered he was discolored, black and purple, and was not breathing. She said she called for nurse (I) and the DON over the walkie talkie. She described resident #1 as having coming from his and running down his . The last time she remembered seeing resident #1 alive was on Thursday . She confirmed she did not start when she first entered the room because she was so "freaked out" by the way he looked. On at 10:35 am, staff J said on Monday he went into resident #1's room between 12 pm and 1 pm to collect the trash. He stated that while collecting the trash, he noticed a smell from the room and saw resident #1 had one off the bed. He recalled his was black in color	A 077		

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A 077	Continued From page 37 and he called for the nurse over the radio then went into the hallway and notified staff (H). He said he last saw the resident on Thursday . On at 11:28 am, dietary staff M confirmed their system only tracked orders and did not alert them if residents missed meals. A review of resident #1's food orders from - found resident #1's last meal in the dining room was at 1:38 pm. On at 9:35 am, the Administrator acknowledged he did not conduct or document an internal investigation regarding the of resident #1. He said a police officer arrived with the ambulance and did his own investigation. He also said residents die all the time in Assisted Living. The Administrator stated he did not think he needed to do an investigation. He confirmed being aware of resident #1 having been found unresponsive because he heard the "chatter" over the radio. He said he did not get involved and did not go to resident #1's room on the 3rd floor. On at 3:50 pm, the DON explained on she was called to resident #1's room by nurse I sometime before lunch. "He was lying on his in bed. He looked and had one , hanging off the bed." The DON said she did not initiate . She left the room and went to the nurse's station on the second floor to notify the resident's family. She then returned to resident #1' room on the 3rd floor and told nurse (I) to start . She did not bring the Automated External Defibrillator ( ) with her from the nurse's station where it was located. She described resident #1 as being bluish and he had some on his sheets. She confirmed she did	A 077		

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A 077	Continued From page 38 not conduct any type of investigation concerning resident #1's and also confirmed the facility did not have a daily check system in place to ensure all residents were okay. She acknowledged the staff did not perform any standard resident checks to ensure residents' wellbeing. The DON was not aware of when the resident had last been in the dining room for a meal and had not checked after his . On at 1:23 pm, the Administrator confirmed every resident in the facility was assigned a call pendant when they moved in, and all resident bathrooms were equipped with emergency call bells. He explained the staff were expected to answer the call bells regardless of the resident's level of care. He said an appropriate time frame for staff to respond to a call bell would be minutes. He confirmed 2 hours and 10 minutes was an excessive amount of time for the call bell to be left unanswered. On at 5:29 pm, Nurse I said Caregivers E and H called her on the walkie talkie about resident #1. She recalled she went to the room and found the resident was , purple, and had , on his . She said he did not have any vital signs and explained the DON told her he was a full code and instructed her to start , . Nurse I noted there was no in the room at that time. On at 5:48 pm, Registered Nurse G said she worked the 11 pm - 7 am shift on and . She stated she turned off the bathroom call light the morning of in resident #1's room and added that Caregiver P was with her. She said the resident was lying in bed under the covers and stated they did not approach the bed because the resident appeared to be sleeping.	A 077		

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A 077	Continued From page 39 She verified she did not assess resident #1 at that time. On at 9:10 am, during a telephone interview, resident #1's son said on he received a call from the DON. She said his father was found unresponsive and was being performed. He said he went to the facility after being notified and explained while waiting for his father to be transferred to the funeral home he reviewed the video from a camera in his father's room. He recalled he had a conversation with the Administrator in the hallway on and told him he was upset about the condition his father's body was in when found. He said he told the Administrator he was shocked to learn his dad was left and not checked on for a couple of days. He stated the Administrator told him his father was independent with care. Review of an internal interrogation performed on for resident #1, noted the the , Defibrillator ( ), resident #1 had, documented an , Episode List. The device identified , on at 4:41 am where the line was identified with an arrow and "flat lined"was written next to the line. On at 10:20 am, an interview was conducted with the Administrator and the DON. The Administrator acknowledged he was not aware of resident #1's call bell not being answered for more than 2 hours on and said he did not go to the resident's room the day he . He also stated he did not have a conversation with resident #1's son in the hallway outside resident #1's room the day he . He confirmed he did not do any type of investigation or interview any staff including the DON regarding	A 077		

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A 077	Continued From page 40 the of resident #1. There was no investigation conducted when resident #1 was found on . Resident #1 had pulled his call bell in the bathroom and there was no response until 2 hours and 10 minutes later when the nurse and caregiver entered the room, turned off the call bell, and left the room. The resident was not checked or assessed, at that time, to determine what his needs were or the reason he pulled the call bell cord. There was no in-services conducted related to resident rights, no in-services related to ( ) / ( ) orders for residents, nor were there any in-services related to the need for daily general health, safety, and physical wellbeing awareness of the residents residing in the Assisted Living Facility. (Photographic Evidence Obtained) Class I	A 077		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee	A 081		

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A 081	Continued From page 41 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 (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	A 081		

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A 081	Continued From page 42 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 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:	A 081		

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A 081	Continued From page 43 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 implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on personnel record review, and interview, the facility failed to ensure 2 of 8 sampled direct care staff (N & P) received 3 hours of in-service	A 081		

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A 081	Continued From page 44 training within 30 days of employment that covered resident behavior and needs and providing assistance with the activities of daily living, (ADLs). Findings: 1. Review of caregiver P's personnel record revealed a hire date of . The record had a 1-hour certificate of training dated on empowering residents through ADLs. The record did not have documentation to indicate the caregiver received an additional 2 hours to meet the requirement for training. There was no documentation to indicate the caregiver was a certified nursing assistant or home health aide to exempt her from the requirement. On at 2:40 pm, the findings were discussed with the human resource manager, who was unable to provide additional documentation. 2. Review of employee N's record revealed she was hired on . Her record did not contain any documentation of a 3 hour training for ADL and Behavioral Needs. On at 3:30 pm in an interview with employee K, she confirmed employee N's file did not contain the three-hour ADL training and Behavioral Needs Training. Class III	A 081		
A 083 SS=D	59A-36.011(5) FAC Training - First Aid and	A 083		

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A 083	Continued From page 45 (5) FIRST AID AND ( ). A staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a staff member who completed in person , , ( ) training was present in the facility at all times. Findings: A review of the staffing schedule revealed nurse G, caregiver N, caregiver P and caregiver W were the only staff who worked on from 11 pm to 7 am. None of their personnel records had documentation to indicate at least one of them held a valid certification on .	A 083		

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A 083	Continued From page 46 On at 10:45 am, a request was made to the Human Resources manager to provide a valid certification for a person who was in the facility on from 11 pm to 7 am but she was unable to do so. Class III	A 083		
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	A 032		

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A 032	Continued From page 47 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: Based on review of the facility's documented elopement drills, personnel record reviews and interview, the facility failed to have documentation of staff participation in a minimum of two resident elopement drills each year for 3 of 9 sampled	A 032		

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A 032	Continued From page 48 staff (G, I, and N.) Findings: 1. Review of nurse G's personnel record revealed a hire date of . The personnel record did not have documentation to indicate the nurse had participated in a minimum of two resident elopement drills during 2023 as required. 2. Review of nurse I's personnel record revealed a hire date of . The personnel record documented the nurse's participation in a resident elopement drill as the only elopement drill in which the nurse was a participant. There was no further documentation to indicate she participated in a minimum of two drills during 2023 as required. On at 2:40 pm, the human resource manager said there were no drills conducted on the 11 pm - 7 am shift during 2023, which was the shift nurse G worked and said nurse I did not work when other drills were conducted during 2023. 3. Review of employee N's personnel record revealed a hire date of . The personnel record did not have documentation to indicate employee N participated in a minimum of two resident elopement drills during 2023 as required. On at 2:30. Interview with Employee K revealed employee N is per diem and only works at night, so it is hard to catch her. Class III	A 032		

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A 078	Continued From page 49	A 078		
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	A 078		

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A 078	Continued From page 50 responsibilities, consistent with their qualifications, to observe residents, to document 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 ˬ 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 the personnel record for 1 of 10 sampled staff (F) had evidence of a negative ( ) examination on an annual basis. Findings: A review of caregiver F's personnel record revealed a hire date of . The record had a freedom from	A 078		

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A 078	Continued From page 51 communicable statement and a , for screening. The record did not have evidence of a negative examination for 2024. On at 2:40 pm, the Human Resources manager said she thought a , was valid for two years. Class III	A 078		
AN277 SS=D	59A-36.022(2) FAC LNS - Resident Care Standards (2) RESIDENT CARE STANDARDS. (a) A resident receiving limited nursing services in a facility holding only a standard and limited nursing services license must meet the admission and continued residency criteria specified in Rule 59A-36.006, F.A.C. (b) In accordance with Rule 59A-36.010, F.A.C., the facility must employ sufficient and qualified staff to meet the needs of residents requiring limited nursing services based on the number of such residents and the type of nursing service to be provided. (c) Limited nursing services may only be provided as authorized by a health care practitioner's order, a copy of which must be maintained in the resident's file. (d) Facilities licensed to provide limited nursing services must employ or contract with a nurse(s) who must be available to provide such services as needed by residents. The facility's employed or nurse must coordinate with third party nursing services providers to ensure resident care is provided in a safe and consistent manner. The facility must maintain documentation of the qualifications of nurses	AN277		

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AN277	Continued From page 52 providing limited nursing services in the facility's personnel files. (e) The facility must ensure that nursing services are conducted and supervised in accordance with Chapter 464, F.S., and the prevailing standard of practice in the nursing community. This Statute or Rule is not met as evidenced by: Based on personnel record review, and interview, the facility failed to employ or contract with either a Registered Nurse (RN) or Advanced Practice Registered Nurse (APRN) to be available to conduct a nursing assessment for residents who receive Limited Nursing Services, (LNS). Findings: On at 9:55 am, the Director of Nursing (DON) said no residents currently received LNS. She said she was employed for three and half years and never had a resident receive LNS. She said the facility called home health agencies to provide nursing services. She was informed the monthly assessments had to be conducted either by a Registered Nurse (RN) or APRN. The administrator then provided a personnel record for Doctor X. Doctor X's personnel record had an agreement ( ) between an Internal Medicine group and the facility for doctor X to conduct monthly nursing assessments for the facility residents receiving LNS. On at 10:15 am, the Administrator said the facility never used its LNS license and that Doctor X was approved during the last AHCA re-licensure survey. Class III	AN277		

Agency for Health Care Administration

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