

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966716	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/20/2025
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PRESTIGE MANOR

**6333 SE BABB ROAD
BELLEVUE, FL 34420**

(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 078	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 disease. 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 tuberculosis 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 tuberculosis testing materials satisfies the annual tuberculosis examination requirement. An individual with a positive tuberculosis test must submit a health care provider's statement that the individual does not constitute a risk of communicating tuberculosis. 2. If any staff member has, or is suspected of having, a communicable disease, 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 disease. (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document	A 078		

AHCA Form 3020-0001

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

TITLE

(X6) DATE

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A 078	Continued From page 1 observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility contracting 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 contracted 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 record reviews and interview, the facility failed to document evidence of an annual negative tuberculosis examination for 3 of 3 staff sampled (Staff C, Caregiver, Staff D, Medication Technician, and Staff F, Resident Aide), and failed to ensure 2 of 3 staff sampled (Staff C, Caregiver and Staff F, Resident Aide) submitted a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable disease within 30 days after beginning employment. Findings include:	A 078			

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A 078	Continued From page 2 Review of employee records conducted on 02/19/2025 revealed Staff C, Caregiver with a hire date of 08/29/2024. Staff C's record did not have documentation evidence of an annual tuberculosis examination. Staff C's record also revealed no written statement from a health care provider documenting that the individual did not have any signs or symptoms of communicable disease. Review of employee records conducted on 02/19/2025 revealed Staff D, Medication Technician with a hire date of 10/31/2015. Staff D's record did not have documentation evidence of an annual tuberculosis examination. Review of employee records conducted on 02/19/2025 revealed Staff F, Resident Aide, with a hire date of 10/8/2024. Staff F's record did not have documentation evidence of an annual tuberculosis examination. Staff F's record also revealed no written statement from a health care provider documenting that the individual did not have any signs or symptoms of communicable disease. During an interview on 02/19/2025 at 2:55 PM, the Administrator stated, "The TB [tuberculosis] test should be every two years, right? I thought it was supposed to be every two years. Yes, I am familiar with the one-time statement that all staff should have." Class III	A 078		
A 081	429.52(1 & 7) FS; 59A-36.011(2-3) FAC Training - Staff In-Service 429.52	A 081		

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A 081	Continued From page 3 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee 's personnel record. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION.	A 081			

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A 081	Continued From page 4 (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in infection control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its infection control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to blood borne pathogens, 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	A 081			

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A 081	Continued From page 5 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 abuse, neglect, and exploitation. The facility must use its abuse 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	A 081			

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A 081	Continued From page 6 policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 2 of 3 staff sampled (Staff C, Caregiver and Staff F, Resident Aide) were provided preservice orientation training and infection control training prior to interacting with residents, and failed to ensure 2 of 3 staff sampled (Staff C, Caregiver and Staff F, Resident Aide) received training on ADL (Activities of Daily Living), resident behavior and needs, elopement training, reporting adverse incidents, and recognizing and reporting resident abuse, neglect, and exploitation. Findings include: Review of employee records conducted on 02/19/2025 revealed Staff C, Caregiver with a hire date of 08/29/2024. Staff C's record did not have documentation evidence of completed pre-service orientation and infection control training prior to interacting with residents. Staff C's record also did not have documentation evidence of completed training in ADL, resident behavior and needs, elopement response, reporting adverse incidents, resident rights, and recognizing and reporting abuse, neglect, and exploitation. Review of employee records conducted on 02/19/2025 revealed Staff F, Resident Aide with a hire date of 10/8/2024. Staff F's record did not have documentation evidence of completed	A 081			

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A 081	Continued From page 7 pre-service orientation training. Staff F's record also did not have documentation evidence of completed training in infection control, ADL, and resident behavior and needs. During an interview on 02/19/2025 at 2:47 PM, the Administrator stated, "I did train with them [staff], and I guess [Assistant Administrator's name] did not put it in the file." Class III	A 081			
A 082	59A-36.011(4) FAC Training - HIV/AIDS (4) HUMAN IMMUNODEFICIENCY VIRUS/ACQUIRED IMMUNE DEFICIENCY SYNDROME (HIV/AIDS). Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on HIV and AIDS, including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 2 of 3 staff sampled (Staff C, Caregiver and Staff F, Resident Aide) completed a one-time education course on Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS.) Findings include: Review of employee records conducted on	A 082			

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A 082	Continued From page 8 02/19/2025 revealed Staff C, Caregiver with a hire date of 08/29/2024. Staff C's records did not have documentation evidence of completed training in HIV/AIDS. Review of employee records conducted on 02/19/2025 revealed Staff F, Resident Aide with a hire date of 10/8/2024. Staff F's records did not have documentation evidence of completed training in HIV/AIDS. During an interview on 02/19/2025 at 2:53 PM, the Administrator stated, "I am aware of all the training that the staff are required to have prior to working with residents. If it's not there, we don't have it. I have no explanation as to why it wouldn't have been in their chart." Class III	A 082			
A 090	59A-36.011(11) FAC Training - Do Not Resuscitate Orders (11) DO NOT RESUSCITATE ORDERS TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding Do Not Resuscitate Orders. (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding DNROs within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C.	A 090			

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A 090	Continued From page 9 This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 3 staff sampled (Staff C, Caregiver) received at least one hour of training in the facility's policy and procedures regarding Do Not Resuscitate Orders within 30 days after employment. Findings include: Review of employee records conducted on 02/19/2025 revealed Staff C, Caregiver with a hire date of 08/29/2024. Staff C's record did not have documentation evidence of a completed training in the facility's policy and procedures regarding Do Not Resuscitate Orders. During an interview on 02/19/2025 at 2:47 PM, the Administrator stated, "I did training with them [staff] and I guess [Assistant Administrator's name] did not put it in the file." Class III	A 090		
A 160	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must	A 160		

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A 160	Continued From page 10 include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a stage 2 pressure sore; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to Rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of death. (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in Rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in Rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with Alzheimer's disease or	A 160		

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A 160	Continued From page 11 related disorders, a copy of all such facility advertisements as required by Section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 59A-36.007, F.A.C. (j) All food service records required in Rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.435, F.S., and rule Chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.; (q) The facility's abuse prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical restraints; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers;	A 160			

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A 160	Continued From page 12 (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.; (w) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain an accurate admission and discharge log of facility residents for 1 of 15 residents reviewed (Resident #1), and failed to provide a facility policy on medication practices. Findings include: During a record review on 2/19/2025 at 2:00 PM of the facility admission and discharge log, the log documented 82 current residents. Resident #1 was documented as being a current resident. During an interview on 2/19/25 at 2:15 PM, the Administrator confirmed the admission/discharge log was not up to date and accurate, and Resident #1 had been discharged to another local assisted living facility. Facility policy on admission/discharge log completion and medication practices was requested from the Administrator on 2/19/25 at 2:17 PM and was not provided during the survey. Class III	A 160		
A 161	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275	A 161		

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A 161	Continued From page 13 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable disease. In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by Rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section 429.174, F.S., and Rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain	A 161			

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NAME OF PROVIDER OR SUPPLIER PRESTIGE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 6333 SE BABB ROAD BELLEVUE, FL 34420		
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A 161	Continued From page 14 personnel records for staff provided by a licensed staffing agency or staff employed by an entity contracting to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by Rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain a copy of the job description given to each staff member for 3 of 3 staff sampled (Staff C, Caregiver, Staff D, Medication Technician, and Staff F, Resident Aide), and failed to maintain a copy of an employment application for 1 of 3 staff sampled (Staff F, Resident Aide.) Findings include: Review of employee records conducted on 02/19/2025 revealed Staff C, Caregiver with a hire date of 08/29/2024. Staff C's record did not contain a copy of a job description. Review of employee records conducted on 02/19/2025 revealed Staff D, Medication Technician with a hire date of 10/31/2015. Staff D's record did not contain a copy of a job description. Review of employee records conducted on 02/19/2025 revealed Staff F, Resident Aide, with a hire date of 10/8/2024. Staff F's record did not contain a copy of an employment application and	A 161			

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A 161	Continued From page 15 a job description. During an interview on 02/19/2025 at 2:56 PM, the Administrator stated, "We talked about that, and I told [Assistant Administrators name] if it's not in the chart, applications, job descriptions, then they didn't do it. The paperwork must be in the chart." Class III	A 161		
A 200	59A-36.025 FAC Emergency Environmental Control 59A-36.025 Emergency Environmental Control for Assisted Living Facilities. (1) DETAILED EMERGENCY ENVIRONMENTAL CONTROL PLAN. Each assisted living facility shall prepare a detailed plan ("plan") to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency environmental control in the event of the loss of primary electrical power in that assisted living facility which includes the following information: (a) The acquisition of a sufficient alternate power source such as a generator(s), maintained at the assisted living facility, to ensure that current licensees of assisted living facilities will be equipped to ensure ambient air temperatures will be maintained at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. 1. The required temperature must be maintained in an area or areas, determined by the assisted living facility, of sufficient size to maintain residents safely at all times and that is appropriate for resident care needs and life safety requirements. For planning purposes, no less than twenty (20) net square feet per resident	A 200		

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A 200	Continued From page 16 must be provided. The assisted living facility may use eighty percent (80%) of its licensed bed capacity as the number of residents to be used in the calculation to determine the required square footage. This may include areas that are less than the entire assisted living facility if the assisted living facility's comprehensive emergency management plan includes allowing a resident to congregate when he or she desires in portions of the building where temperatures will be maintained and includes procedures for monitoring residents for signs of heat related injury as required by this rule. This rule does not prohibit a facility from acting as a receiving provider for evacuees when the conditions stated in Section 408.821, F.S. and subsection 59A-36.019(5), F.A.C., are met. The plan shall include information regarding the area(s) within the assisted living facility where the required temperature will be maintained. 2. The alternate power source and fuel supply shall be located in an area(s) in accordance with local zoning and the Florida Building Code. 3. Each assisted living facility is unique in size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and staffing characteristics. Accordingly, this rule does not limit the types of systems or equipment that may be used to achieve ambient temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. The plan shall include information regarding the systems and equipment that will be used by the assisted living facility and the fuel required to operate the systems and equipment. a. An assisted living facility in an evacuation zone pursuant to Chapter 252, F, S. must maintain an	A 200			

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A 200	Continued From page 17 alternative power source and fuel as required by this subsection at all times when the assisted living facility is occupied but is permitted to utilize a mobile generator(s) to enable portability if evacuation is necessary. b. Assisted living facilities located on a single campus with other facilities under common ownership, may share fuel, alternative power resources, and resident space available on the campus if such resources are sufficient to support the requirements of each facility's residents, as specified in this rule. Details regarding how resources will be shared and any necessary movement of residents must be clearly described in the emergency power plan. c. A multistory facility, whose comprehensive emergency management plan is to move residents to a higher floor during a flood or surge event, must place its alternative power source and all necessary additional equipment so it can safely operate in a location protected from flooding or storm surge damage. (b) The acquisition of sufficient fuel, and safe maintenance of that fuel at the facility, to ensure that in the event of the loss of primary electrical power there is sufficient fuel available for the alternate power source to maintain ambient temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours after the loss of primary electrical power during a declared state of emergency. The plan must include information regarding fuel source and fuel storage. 1. Facilities must store minimum amounts of fuel onsite as follows: a. A facility with a licensed capacity of 16 beds or less must store 48 hours of fuel onsite. b. A facility with a licensed capacity of 17 or more beds must store 72 hours of fuel onsite.	A 200			

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A 200	Continued From page 18 2. An assisted living facility located in an area in a declared state of emergency area pursuant to Section 252.36, F.S. that may impact primary power delivery must secure ninety-six (96) hours of fuel. The assisted living facility may utilize portable fuel storage containers for the remaining fuel necessary for ninety-six (96) hours during the period of a declared state of emergency. 3. Piped natural gas is an allowable fuel source and meets the onsite fuel supply requirements under this rule. 4. If local ordinances or other regulations limit the amount of onsite fuel storage for the assisted living facility's location, then the assisted living facility must develop a plan that includes maximum onsite fuel storage allowable by the ordinance or regulation and a reliable method to obtain the maximum additional fuel at least 24 hours prior to depletion of onsite fuel. (c) The acquisition of services necessary to maintain, and test the equipment and its functions to ensure the safe and sufficient operation of the alternate power source maintained at the assisted living facility. (d) The acquisition and maintenance of a carbon monoxide alarm. (2) SUBMISSION OF THE PLAN. (a) Each new assisted living facility shall submit the plan required under this rule prior to obtaining a license. (b) Each existing assisted living facility that undergoes any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of its systems or equipment affecting the facility's compliance with this rule shall amend its plan and submit it to the county emergency management agency for review and approval. (3) APPROVED PLANS.	A 200			

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A 200	Continued From page 19 (a) Each assisted living facility must maintain a copy of its approved plan in a manner that makes the plan readily available at the licensee's physical address for review by a legally authorized entity. If the plan is maintained in an electronic format, assisted living facility staff must be readily available to access and produce the plan. For purposes of this section, "readily available" means the ability to immediately produce the plan, either in electronic or paper format, upon request. (b) Within 30 days of the approval of the plan from the county emergency management agency, the assisted living facility shall submit in writing proof of the approval to the Agency for Health Care Administration to assistedliving@ahca.myflorida.com. (c) The assisted living facility shall submit a consumer-friendly summary of the emergency power plan to the Agency. The Agency shall post the summary and notice of the approval and implementation of the assisted living facility emergency power plans on its website within ten (10) business days of the plan's approval by the county emergency management agency and update within ten (10) business days of implementation. (4) IMPLEMENTATION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall, no later than June 1, 2018, have implemented the plan required under this rule. (b) Each new assisted living facility shall implement the plan required under this rule prior to obtaining a license. (c) Existing assisted living facilities that undergo any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of the systems or equipment	A 200			

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A 200	Continued From page 20 affecting the assisted living facility's compliance with this rule shall implement its amended plan concurrent with any such additions, modifications, alterations, refurbishment, renovations or reconstruction. (5) POLICIES AND PROCEDURES. (a) Each assisted living facility shall develop and implement written policies and procedures to ensure that the assisted living facility can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. The procedures shall ensure that residents do not experience complications from fluctuations in ambient air temperatures inside the facility. Procedures must address the care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury including: 1. The use of cooling devices and equipment; 2. The use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration; 3. Wellness checks by assisted living facility staff to monitor for signs of dehydration and heat injury; and 4. A provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy. (b) Each assisted living facility shall maintain the written policies and procedures in a manner that makes them readily available at the licensee's physical address for review by a legally authorized entity. If the policies and procedures are maintained in an electronic format, assisted living facility staff must be readily available to access the policies and procedures and produce the requested information. For purposes of this	A 200			

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A 200	Continued From page 21 section, "readily available" means the ability to immediately produce the policies and procedures, either in electronic or paper format, upon request. (c) The written policies and procedures must be readily available for inspection by each resident; each resident's legal representative, designee, surrogate, guardian, attorney in fact, or case manager; each resident's estate; and such additional parties as authorized in writing or by law. (6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this rule, the Agency for Health Care Administration may seek any remedy authorized by Chapter 429, Part I, or Chapter 408, Part II, F.S., including, but not limited to, license revocation, license suspension, and the imposition of administrative fines. (7) COMPREHENSIVE EMERGENCY MANAGEMENT PLAN. (a) Assisted living facilities whose comprehensive emergency management plan is to evacuate must comply with this rule. (b) Each facility whose plan has been approved shall submit the plan as an addendum with any future submissions for approval of its comprehensive emergency management plan. (8) NOTIFICATION. (a) Within five (5) business days, each assisted living facility must notify in writing, unless permission for electronic communication has been granted, each resident and the resident's legal representative: 1. Upon the initial submission of the plan to the county emergency management agency that the plan has been submitted for review and approval; 2. Upon final implementation of the plan by the assisted living facility. 3. Annual submissions and approvals of the plan	A 200			

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A 200	Continued From page 22 do not require notification to residents or their legal representatives unless a significant modification as defined in Rule 59A-36.019, F.A.C., has been made to the plan. (b) Each assisted living facility must maintain a copy of each notification set forth in paragraph (a) above in a manner that makes each notification readily available at the licensee's physical address for review by a legally authorized entity. If the notifications are maintained in an electronic format, facility staff must be readily available to access and produce the notifications. For purposes of this section, "readily available" means the ability to immediately produce the notifications, either in electronic or paper format, upon request. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop and implement a written policy and procedure to ensure that the assisted living facility can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. Findings include: Review of the facilities Emergency Management Plan conducted on 02/19/2025 revealed no written policy and procedure to ensure that the assisted living facility can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. During an interview on 02/19/2025 at 10:51 AM, the Maintenance Person stated, "I don't have any written policies and procedures regarding the generator. I am not responsible for having	A 200			

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A 200	Continued From page 23 policies and procedures. No, I do not test the generator monthly. The generator comes on every so often on its own. If a fuse or something blows, I fix that, but that's about it." Class III	A 200			
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the fingerprints are enrolled in the national retained print arrest notification program at the Federal Bureau of Investigation: 1. A person with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. 2. Effective January 1, 2026, or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity. (c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse. 1. Before January 1, 2024, initial status and any	CZ814			

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CZ814	Continued From page 24 changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person ' s status has been made. 2. Effective January 1, 2024, initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person ' s status has been made. (d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic fingerprint submission to the Department of Law Enforcement. The registration must include the person ' s full first name, middle initial, and last name; social security number; date of birth; mailing address; sex; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to report the change of employment status for 1 of 6 (Staff E, Home Health Aide) sampled employees within five business days to the Agency for Health Care Administration (AHCA) Background Screening Clearing House (BGS.) Findings include: Review of the employee list provided by the facility did not list Staff E on the BGS employee roster.	CZ814			

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CZ814	Continued From page 25 Review of the facility's work schedule for 2/18/25 listed Staff E as working from 7:00 AM until 3:00 PM. Review of the facility's employee roster on AHCA's BGS Internet website revealed Staff E had an end date (termination date) from the facility of 4/21/19. No new background screening was completed. During an interview on 2/20/25 at 10:37 AM, the Assistant Administrator stated, "[Staff E's Name] was rehired on 11/6/23. A new screening was not completed. I just looked at the roster yesterday. I did not realize she [Staff E] was not on it. I will have to update it." Unclassified	CZ814		
CZ815	408.809(1)(3-8); 435.02(2); 435.06 FS Background Screening; Prohibited Offenses 408.809 Background screening; prohibited offenses.- (1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are considered employees for the purposes of conducting screening under chapter 435: (a) The licensee, if an individual. (b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider. (c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider. (d) Any person who is a controlling interest. (e) Any person, as required by authorizing	CZ815		

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CZ815	Continued From page 26 statutes, seeking employment with a licensee or provider who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, contracting with a licensee or provider whose responsibilities require him or her to provide personal care or personal services directly to clients, or contracting with a licensee or provider to work 20 hours a week or more who will have access to client funds, personal property, or living areas. Evidence of contractor screening may be retained by the contractor's employer or the licensee. (3) All fingerprints must be provided in electronic format. Screening results shall be reviewed by the agency with respect to the offenses specified in s. 435.04 and this section, and the qualifying or disqualifying status of the person named in the request shall be maintained in a database. The qualifying or disqualifying status of the person named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee's behalf. (4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an arrest awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction: (a) Any authorizing statutes, if the offense was a	CZ815		

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NAME OF PROVIDER OR SUPPLIER PRESTIGE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 6333 SE BABB ROAD BELLEVUE, FL 34420		
(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	
CZ815	Continued From page 27 felony. (b) This chapter, if the offense was a felony. (c) Section 409.920, relating to Medicaid provider fraud. (d) Section 409.9201, relating to Medicaid fraud. (e) Section 741.28, relating to domestic violence. (f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection. (g) Section 784.03, relating to battery, if the victim is a vulnerable adult as defined in s. 415.102 or a patient or resident of a facility licensed under chapter 395, chapter 400, or chapter 429. (h) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems. (i) Section 817.234, relating to false and fraudulent insurance claims. (j) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony. (k) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider. (l) Section 817.505, relating to patient brokering. (m) Section 817.568, relating to criminal use of personal identification information. (n) Section 817.60, relating to obtaining a credit card through fraudulent means. (o) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony. (p) Section 831.01, relating to forgery. (q) Section 831.02, relating to uttering forged instruments. (r) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes. (s) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes. (t) Section 831.30, relating to fraud in obtaining	CZ815			

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CZ815	Continued From page 28 medicinal drugs. (u) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony. (v) Section 895.03, relating to racketeering and collection of unlawful debts. (w) Section 896.101, relating to the Florida Money Laundering Act. If, upon rescreening, a person who is currently employed or contracted with a licensee and was screened and qualified under s. 435.04 has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency no later than 30 days after receipt of the rescreening results by the person. (5) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening. (6)(a) As provided in chapter 435, the agency may grant an exemption from disqualification to a person who is subject to this section and who:	CZ815			

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CZ815	Continued From page 29 1. Does not have an active professional license or certification from the Department of Health; or 2. Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification. (b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may grant an exemption from disqualification to a person who is subject to this section and who has received a professional license or certification from the Department of Health or a regulatory board within that department and that person is providing a service within the scope of his or her licensed or certified practice. (7) The agency and the Department of Health may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, chapter 435, and authorizing statutes requiring background screening and to implement and adopt criteria relating to retaining fingerprints pursuant to s. 943.05(2). (8) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this section, terminates the person against whom the report was issued, whether or not that person has filed for an exemption with the Department of Health or the agency. 435.06 Exclusion from employment.- (1) If an employer or agency has reasonable cause to believe that grounds exist for the denial or termination of employment of any employee as	CZ815			

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CZ815	Continued From page 30 a result of background screening, it shall notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity. (2)(a) An employer may not hire, select, or otherwise allow an employee to have contact with any vulnerable person that would place the employee in a role that requires background screening until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of employment. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select, or otherwise allow the employee to have contact with any vulnerable person that would place the employee in a role that requires background screening unless the employee is granted an exemption for the disqualification by the agency as provided under s. 435.07. (b) If an employer becomes aware that an employee has been arrested for a disqualifying offense, the employer must remove the employee from contact with any vulnerable person that places the employee in a role that requires background screening until the arrest is resolved in a way that the employer determines that the employee is still eligible for employment under this chapter. (c) The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of this chapter or place the employee in a position for which background screening is not required unless the employee is granted an exemption	CZ815			

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CZ815	Continued From page 31 from disqualification pursuant to s. 435.07. (d) An employer may hire an employee to a position that requires background screening before the employee completes the screening process for training and orientation purposes. However, the employee may not have direct contact with vulnerable persons until the screening process is completed and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment. (3) Any employee who refuses to cooperate in such screening or refuses to timely submit the information necessary to complete the screening, including fingerprints if required, must be disqualified for employment in such position or, if employed, must be dismissed. (4) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages against, an employer that, upon notice of a conviction or arrest for a disqualifying offense listed under this chapter, terminates the person against whom the report was issued or who was arrested, regardless of whether or not that person has filed for an exemption pursuant to this chapter. 435.02 Definitions.-For the purposes of this chapter, the term: (2) "Employee" means any person required by law to be screened pursuant to this chapter, including, but not limited to, persons who are contractors, licensees, or volunteers. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure Level II background screenings were completed for 3 of 6 sampled staff, Staff E, Home Health Aide, Staff H, Activities, and Staff J, Home Health Aide.	CZ815			

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CZ815	Continued From page 32 Findings Include: Review of employee records revealed Staff E was hired on 11/6/23. A review of the Agency for Health Care Background Screening Clearinghouse showed a new screening is required. Review of employee records revealed Staff H was hired on 5/3/10. A review of the Agency for Health Care Background Screening Clearinghouse showed a new screening is required. Review of employee records revealed Staff J was hired on 3/27/14. A review of the Agency for Health Care Background Screening Clearinghouse showed a new screening is required. During an interview on 2/20/25 at 10:40 AM, the Assistant Administrator stated, "I usually receive an email to notify me when a new screening is needed. I will have to get the new screenings." Unclassified	CZ815		
CZ816	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	CZ816		

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CZ816	Continued From page 33 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 fingerprints to the Federal Bureau of Investigation for a national criminal history record check unless the person's fingerprints are enrolled in the Federal Bureau of Investigation's national retained print arrest notification program. If the fingerprints 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 fingerprints electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the fingerprints to the Federal Bureau of Investigation for a national criminal history record check. The fingerprints shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print arrest 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 fingerprinted. 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 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;	CZ816			

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CZ816	Continued From page 34 (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 arrested 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, January 2017, 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/s/Background_Screening/Regulations_Forms.shtm. 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 arrested for any disqualifying offense.	CZ816		

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CZ816	Continued From page 35 (e) An administrator or chief financial officer must be screened and qualified prior to appointment 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 arrest 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 record review and interviews, the facility failed to ensure 4 of 6 sampled staff (Staff C, Caregiver, Staff D, Medication Technician, Staff F, Resident Aide, and Staff H, Activities) completed an Attestation of Compliance with Background Screening Requirements, Agency for Health Care Administration (AHCA) Form 3100-0008. Findings include: Review of employee records conducted on 02/19/2025 revealed Staff C with a hire date of 08/29/24. Staff C's record had no evidence of a	CZ816		

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CZ816	Continued From page 36 signed Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008. Review of employee records conducted on 02/19/2025 revealed Staff D with a hire date of 10/31/15. Staff D's record had no evidence of a signed Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008. Review of employee records conducted on 02/19/2025 revealed Staff F with a hire date of 10/08/2024. Staff F's record had no evidence of a signed Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008. Review of employee records conducted on 02/20/2025 revealed Staff H with a hire date of 05/03/2010. Staff H's record had no evidence of a signed Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008. During an interview on 02/20/2025 at 10:45 AM, the Assistant Administrator stated, "I know what the attestation form is and some of the staff did have it." Unclassified	CZ816			
CZ821	59A-35.110(1-2) FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is	CZ821			

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CZ821	Continued From page 37 required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, April 2017, which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident	CZ821		

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CZ821	Continued From page 38 as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, April 2017, which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, April 2017, which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, April 2017, which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On	CZ821			

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CZ821	Continued From page 39 Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, May 2018, which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 6. For the purposes of this rule, the following applies for submitting adverse incident reports: a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up to \$50 per day late not to exceed \$500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the	CZ821			

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CZ821	Continued From page 40 online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to file a 15-day adverse incident report to the Agency for Healthcare Administration (AHCA) for 1 out of 2 adverse incidents reviewed, an elopement that occurred on 1/7/2025 involving Resident #1. Findings include: Review of the AHCA adverse incident report database revealed a one-day incident report for an elopement on 1/7/2025 involving Resident #1. A 15-day report was not located in the database. Review of a law enforcement incident report, dated 1/7/2025, documented Resident #1 was found at a private residence and was returned to the facility the same night. During an interview on 2/17/2025 at 10:05 AM, the Assistant Administrator confirmed the 15-day report was not completed for the elopement on 1/7/2025. She stated, "We have been having problems with uploading and completing reports on the system." Facility policy on submission of adverse incident reports was requested from the Administrator on 2/19/2025 at 3:30 PM. During an interview on 2/19/2025 at 3:30 PM, the Administrator stated, "We do not have a direct	CZ821			

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CZ821	Continued From page 41 policy on submission of reports. We follow the AHCA guidelines." Class III	CZ821		
CZ830	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 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	CZ830		

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CZ830	Continued From page 42 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 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	CZ830		

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CZ830	Continued From page 43 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 interviews, the facility failed to submit their comprehensive emergency management plan to the local emergency management agency annually. Findings include: Review of the facility's comprehensive emergency management plan, conducted on 02/18/2025, revealed an approval letter dated 10/11/2023. There was no documentation of an approval letter for the current year. During an interview on 02/18/2025 at 1:22 PM, the Assistant Administrator stated, "Let me check my email, I don't think I have it." During an interview on 02/18/2025 at 3:02 PM, the Administrator stated she [the Assistant Administrator] thought that the plan was due every two years because that's how long the contractors sign their contracts for. The Administrator confirmed that she has not submitted the plan. Class III	CZ830			

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CZ875	Continued From page 44	CZ875			
CZ875	430.5025(4 & 7-9) Alzheimer disease/dementia; Training (4) Employees of covered providers must complete the following training for Alzheimer's disease and related forms of dementia: (a) Upon beginning employment, each employee must receive basic written information about interacting with persons who have Alzheimer's disease or related forms of dementia. (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 dementia, how to identify the signs and symptoms of dementia, and skills for communicating and interacting with persons with Alzheimer ' s disease or related forms of dementia. 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	CZ875			

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CZ875	Continued From page 45 for a home health agency, nurse registry, or companion or homemaker service provider, each employee who provides personal care must complete 2 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, and skills in working with families and caregivers. (d) Within 7 months after beginning employment for a nursing home, an assisted living facility, an adult family-care home, or an adult day care center, each employee who provides personal care must complete 3 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, skills in working with families and caregivers, group and individual activities, maintaining an appropriate environment, and ethical issues. (e) For an assisted living facility, adult family-care home, or adult day care center that advertises and provides, or is designated to provide, specialized care for persons with Alzheimer's disease or related forms of dementia, 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 dementia-specific training. Such training must include, but is not limited to, understanding Alzheimer's disease and related forms of	CZ875			

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CZ875	Continued From page 46 dementia, the stages of Alzheimer's disease, 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 technology. 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 hands-on experience to help develop and refine the employee's skills for caring for a person with Alzheimer's disease or a related form of dementia. The continuing education must cover at least one of the topics included in the dementia-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 technology 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.	CZ875			

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CZ875	Continued From page 47 400.980(5) before providing, assigning, or referring an employee to a covered provider. (7) For a certified nursing assistant as defined in s. 464.201, training hours completed as required under this section may count toward the total hours of training required to maintain certification as a nursing assistant. (8) For a health care practitioner as defined in s. 456.001, training hours completed as required under this section may count toward the total hours of continuing education required by that practitioner's licensing board. (9) Each person employed, contracted, or referred to provide services before July 1, 2023, must complete the training required in this section before July 1, 2026. Proof of completion of equivalent training completed before July 1, 2023, shall substitute for the training required in subsection (4). Each person employed, contracted, or referred to provide services on or after July 1, 2023, 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 2 of 3 staff sampled (Staff C, Caregiver and Staff F, Resident Aide) completed a 1-hour training program for Alzheimer's disease and related forms of dementia within 30 days after beginning employment. Findings include: Review of employee records conducted on 02/19/2025 revealed Staff C with a hire date of 08/29/2024. Staff C's record did not have documentation of a completed 1-hour training	CZ875			

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CZ875	Continued From page 48 program provided by the Department of Elder Affairs. Review of employee records conducted on 02/19/2025 revealed Staff F with a hire date of 10/08/2024. Staff F's record did not have documentation of a completed 1-hour training program provided by the Department of Elder Affairs. During an interview on 02/19/2025 at 2:59 PM, the Administrator stated, "I am not familiar with the 1-hour training program provided by the Department of Elder Affairs." Class III	CZ875			
A 000	Initial Comments An unannounced re-licensure survey with Emergency Power Plan monitoring and a complaint investigation (complaint number 2025001593) were conducted at Prestige Manor on February 17, 2025 through February 20, 2025. Deficiencies were identified at the time of the survey.	A 000			
A 008	429.26(5-6) FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a	A 008			

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A 008	Continued From page 49 form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner's direct observation of the patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form, reflecting the resident's condition on the date the examination is performed, becomes a permanent part of the facility's record of the resident and must be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or	A 008			

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A 008	Continued From page 50 administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or psychiatric nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of optional state supplementation require such assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a face-to-face medical examination completed by a health care practitioner as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 days before or within 30 days after the individual's	A 008			

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A 008	Continued From page 51 admission to a facility pursuant to Section 429.26(5), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations, 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living, 3. Any nursing or therapy services required by the individual, 4. Any special diet required by the individual, 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication, 6. Whether the individual has signs or symptoms of Tuberculosis, Methicillin Resistant Staphylococcus Aureus, Scabies or any other communicable disease, which are likely to be transmitted to other residents or staff, 7. A statement on the day of the examination that, in the opinion of the examining health care practitioner, the individual's needs can be met in an assisted living facility; and, 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care practitioner. (b) When a health care practitioner conducts a medical examination, the examination must be recorded on the practitioner's form or on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, April 2021, which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-13531 . Faxed or electronic copies of the completed form are acceptable. If AHCA Form 1823 is used, the form must be completed as instructed.	A 008			

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A 008	Continued From page 52 1. If the health care practitioner's form does not include all the examination items on AHCA Form 1823 or if AHCA Form 1823 is not completed fully, then the omitted items may be obtained by the administrator or designee either orally or in writing from the health care practitioner. The missing or omitted information must be obtained and documented in the resident's record within 30 days after the resident's admission to the facility. 2. Omitted or missing information received orally must include the name of the health care practitioner, the name and signature of the administrator or designee recording the information, and the date the information was provided. (c) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (d) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.26, F.S. and this rule. (e) Any orders issued by the health care practitioner conducting the medical examination for medications, nursing services, treatments, therapy, or therapeutic diets, may be attached to the health assessment. A health care practitioner may attach a DH Form 1896, Florida Do Not Resuscitate Order Form, for residents who do not wish cardiopulmonary resuscitation to be administered in the case of cardiac or respiratory arrest. (f) A resident placed in a facility on a temporary emergency basis by the Department of Children	A 008		

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NAME OF PROVIDER OR SUPPLIER PRESTIGE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 6333 SE BABB ROAD BELLEVUE, FL 34420		
(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 008	Continued From page 53 and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure accurate health assessments were completed for 2 of 4 residents reviewed, Resident #2 and Resident #11. Findings include: Review of Resident #2's Resident Health Assessment for Assisted Living Facilities, Agency for Health Care Administration (AHCA) Form 1823, dated 11/30/2023, documented the resident as needing medication administration. Review of the facility staff roster documented the facility employs medication technicians. No Licensed Practical Nurses or Registered Nurses were on the staff roster. Review of the staff schedule for 2/09/2025 through 2/22/2025 documented medication technicians indicated by "M", "MT", or "Lead." No nurses were on the schedule. Review of Resident #11's AHCA Form 1823, dated 2/5/2025, does not document date of birth for Resident #11.	A 008			

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A 008	Continued From page 54 During an interview on 2/18/2025 at 2:00 PM with Resident #11's Advanced Practical Registered Nurse (APRN), she confirmed Resident #11 did not need medication administration and provided a new 1823 dated 2/18/2025 which documents Resident #11 as needing assistance with self-administration of medications. During an interview on 2/19/2025 at 12:45 PM, the Administrator confirmed Resident #2's AHCA Form 1823, dated 11/30/2023, was the form which was being followed at the beginning of the survey. A new AHCA Form 1823 was provided by the APRN on 2/18/2025. She stated, "We do not have nurses here. She [Resident #2] should be documented as needing assistance with self-administration of medications." The Administrator confirmed that Resident #11's AHCA Form 1823 did not document his date of birth. Facility policy on completion and accuracy of Resident Health Assessments was requested from the Administrator on 1/19/2025 at 3:24 PM and was not provided during the survey. Class III	A 008			
A 051	59A-36.008(2) FAC Medication - Pill Organizers (2) PILL ORGANIZERS. (a) Only a resident who self-administers medications may maintain a pill organizer. (b) Unlicensed staff may not provide assistance with the contents of pill organizers. (c) A nurse may manage a pill organizer to be used only by residents who self-administer medications. The nurse is responsible for	A 051			

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A 051	Continued From page 55 instructing the resident in the proper use of the pill organizer. The nurse must manage the pill organizer in the following manner: 1. Obtain the labeled medication container from the storage area or the resident, 2. Transfer the medication from the original container into a pill organizer, labeled with the resident's name, according to the day and time increments as prescribed, 3. Return the medication container to the storage area or resident; and, 4. Document the date and time the pill organizer was filled in the resident's record. (d) If there is a determination that the resident is not taking medications as prescribed after the medicinal benefits are explained, it must be noted in the resident's record and the facility must consult with the resident concerning providing assistance with self-administration or the administration of medications if such services are offered by the facility. The facility must contact the resident's health care provider regarding questions, concerns, or observations relating to the resident's medications. Such communication must be documented in the resident's record. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a resident who maintained a pill organizer had been assessed as being able to self-administer their own medications for 1 out of 4 residents reviewed for medication assistance, Resident #15. Findings include: Review of Resident #15's Resident Health Assessment for Assisted Living Facilities, Agency for Health Care Administration (AHCA) Form 1823, dated 1/6/2025, documented the resident	A 051		

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A 051	Continued From page 56 as needing assistance with self-administration of medications. During an observation of Resident #15's room conducted with the Administrator on 2/19/2025 at 3:15 PM, a pill organizer filled with various medications was observed on the end table next to Resident #15, who was sitting in her recliner. During an interview on 2/19/2025 at 3:17 PM, Resident #15 stated, "Those are my medications. My daughter puts them into the pill organizer for me." During an interview on 2/19/2025 at 3:20 PM, the Administrator stated, "[Resident #15's Name] should not have pill organizers unless she is documented as self-administration, which she is not." The Administrator confirmed Resident #15's AHCA Form 1823 documented the resident as needing assistance with self-administration of medication. Facility policy on residents utilizing pill organizers was requested from the Administrator on 1/19/25 at 3:24 PM. The policy was not provided during the survey. Class III	A 051			
A 054	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the	A 054			

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A 054	Continued From page 57 resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known allergies the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical restraints, the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the assistance with self-administration of medications was documented for 1 out of 5 residents reviewed for assistance with self-administration of medications, Resident #11. Findings include: Review of Resident #11's Medication Observation Record (MOR) for 2/8/2025 through 2/12/2025 documented on 2/8/25 at 8:09 AM, "resident refused- not given", 2/10/25 at 8:26 AM, "resident	A 054			

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A 054	Continued From page 58 refused-D/C" (discontinued), 2/11/25 at 8:24 AM, "resident refused-D/C", and on 2/12/25 at 7:56 AM- "resident refused-D/C." During an interview on 2/19/2025 at 2:30 PM, Staff D, Medication Technician, reported that the staff records "resident refused medication" and "D/C" on the MOR when there is no medication in the med cart and the medication has been discontinued, because they only have a limited choice of reasons in the electronic record why the medications were not observed. During an interview on 2/19/2025 at 2:35 PM, the Assistant Administrator confirmed staff were inaccurately documenting Resident #11's medications. She stated, "His Lasix had been discontinued, but not removed from the medication administration observation records." Review of Resident #11's physician orders documented an order dated 11/19/2024, with no end date, for Furosemide 40 mg (milligrams) tablet (Lasix)-take one tablet each day. Request of facility policy on ensuring residents are on all physician ordered medications was requested from the Administrator on 2/19/2025 and was not provided during the survey. Class III	A 054		
A 055	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible,	A 055		

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A 055	Continued From page 59 residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the	A 055			

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A 055	Continued From page 60 refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit	A 055			

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A 055	Continued From page 61 issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to securely store medications which require refrigeration in one refrigerator out of two refrigerators in the building. Findings include: During an observation on 2/19/25 at 2:24 PM of the refrigerator in the second building's dining area, 3 boxes of residents' insulin were observed in a compartment on the refrigerator door. There was no lock on the compartment. During an interview on 2/19/25 at 2:25 PM, the Assistant Administrator confirmed the residents' refrigerated insulin should be stored in a locked container. Facility policy on medication storage was requested from the Administrator on 2/19/25 at 2:30 PM and was not received during the survey. Class III	A 055			