Agency for Health Care Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11968840 | A. BUILDING: _____ B. WING _____ | 03/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND ASSISTED LIVING AND MEMORY CARE | 3339 HWY 17 GREEN COVE SPRINGS, FL 32043 |

| (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 |
|---|---|---|---|---|
| ZZ830 | 408.821 FS Emergency Management Planning<br><br>408.821 Emergency management planning; emergency operations; inactive license.-<br>(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:<br>(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.<br>(b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan.<br>(c) Submit necessary plan revisions within 30 days after notification that plan revisions are required.<br>(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.<br>(2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers.<br>(3)(a) An inactive license may be issued to a licensee subject to this section when the provider | ZZ830 | | |

AHCA Form 3020-0001

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

Agency for Health Care Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11968840 | A. BUILDING: _____ B. WING _____ | 03/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND ASSISTED LIVING AND MEMORY CARE | 3339 HWY 17 GREEN COVE SPRINGS, FL 32043 |

| (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 |
|---|---|---|---|---|
| ZZ830 | Continued From page 1<br><br>is located in a geographic area in which a state of emergency was declared by the Governor if the provider:<br>1. Suffered damage to its operation during the state of emergency.<br>2. Is currently licensed.<br>3. Does not have a provisional license.<br>4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months.<br>(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 renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes.<br><br>(4) . . . Licensees providing residential or inpatient services must utilize an online database | ZZ830 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11968840 | A. BUILDING: _____ B. WING _____ | 03/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND ASSISTED LIVING AND MEMORY CARE | 3339 HWY 17 GREEN COVE SPRINGS, FL 32043 |

| (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 |
|---|---|---|---|---|
| ZZ830 | Continued From page 2<br><br>approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure the Comprehensive Emergency Management Plan (CEMP), for use by staff in an emergency to ensure the safety of residents, was submitted on an annual basis.<br><br>The findings include:<br><br>Review of the CEMP information provided by the facility showed the most recent approval from the county approver was dated . No approvals past this date were located.<br><br>In an interview with the Administrator on at 2:45pm, she stated since she just started she understood the need to work with the county approver since her predecessor did not leave evidence the CEMP was submitted annually.<br><br>Class III | ZZ830 | | |
| A 000 | Initial Comments<br><br>A Change of Ownership survey with complaint investigation (2023015547, 2024008796, 2025002620) was conducted at Diamond Assisted Living and Memory Care from to . Deficiencies were identified at the time of the survey. | A 000 | | |
| A 052 | 429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin | A 052 | | |

Agency for Health Care Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11968840 | A. BUILDING: _____ B. WING _____ | 03/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND ASSISTED LIVING AND MEMORY CARE | 3339 HWY 17 GREEN COVE SPRINGS, FL 32043 |

| (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 052 | Continued From page 3<br><br>429.256<br>(3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers.<br>(b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change.<br>(c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her .<br>(d) Applying , medications.<br>(e) Returning the medication container to proper storage.<br>(f) Keeping a record of when a resident receives assistance with self-administration under this section.<br>(g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into | A 052 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11968840 | A. BUILDING: _____ B. WING _____ | 03/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND ASSISTED LIVING AND MEMORY CARE | 3339 HWY 17 GREEN COVE SPRINGS, FL 32043 |

| (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 052 | Continued From page 4<br><br>the dispensing cup of the .<br>(4) Assistance with self-administration of medication does not include:<br>(a) Mixing, , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed.<br>(b) The preparation of syringes for injection or the administration of medications by any injectable route.<br>(c) Administration of medications by way of a tube inserted in a of the body.<br>(d) Administration of preparations.<br>(e) The use of irrigations or debriding agents used in the treatment of a skin condition.<br>(f) Assisting with , , or preparations.<br>(g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication.<br>(h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.<br>(5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003.<br><br>59A-36.008<br>(3) ASSISTANCE WITH | A 052 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11968840 | A. BUILDING: _____ B. WING _____ | 03/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND ASSISTED LIVING AND MEMORY CARE | 3339 HWY 17 GREEN COVE SPRINGS, FL 32043 |

| (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 052 | Continued From page 5<br><br>SELF-ADMINISTRATION.<br>(a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule.<br>(b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed.<br>(c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container.<br>(d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record.<br>(e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed:<br>1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility,<br>2. The medication container may be given to the resident, a friend, or family member upon leaving | A 052 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11968840 | A. BUILDING: _____ B. WING _____ | 03/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND ASSISTED LIVING AND MEMORY CARE | 3339 HWY 17 GREEN COVE SPRINGS, FL 32043 |

| (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 052 | Continued From page 6<br><br>the facility, with this fact noted in the resident's medication record,<br>3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or<br>4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging.<br>(f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S.<br>(g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition.<br>(h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation and interview, the facility failed to ensure 3 of 3 sampled residents received proper assistance with self-administration of medication, evidenced by failing to prepare medications in the presence of the resident, and failing to properly update the Medication Observation Record (MOR).<br><br>The findings include:<br><br>During an observation of Employee C, Medication Technician, assisting Resident 8 with medications on at 1:10pm, he wheeled the medication cart outside of her doorway. Resident 8 was inside the room outside of Employee C's | A 052 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11968840 | A. BUILDING: _____ B. WING _____ | 03/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND ASSISTED LIVING AND MEMORY CARE | 3339 HWY 17 GREEN COVE SPRINGS, FL 32043 |

| (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 052 | Continued From page 7<br><br>area. Employee C prepared the , for Resident 8 and at 1:09pm on , signed the MOR to indicate the resident got the medication. Employee C then entered Resident 8's room, provided the medication, then returned to the cart.<br><br>Employee C then wheeled the cart outside of Resident 6's room, where she was inside, and not present when the medications were being prepared at 1:13pm on . Employee C prepared the Miodrine, signed the MOR, then reentered Resident 6's room to provide the medications.<br><br>At 1:18pm on , Employee C began preparing medications for Resident 2 in the hallway outside of her room, when she was not present. Employee C prepared the medications, signed the MOR at 1:18pm on , then entered her room to supply the medication.<br><br>During an interview at 1:38pm on , Employee C explained his process was to fill in the MOR when he popped the medications.<br><br>The Wellness Director was interviewed at 2:05pm on and confirmed the expectation to prepare medications in the presence of residents and the importance of accurate MORs.<br><br>Class III | A 052 | | |
| A 076 | 59A-36.009 FAC<br>( )<br><br>(1) POLICIES AND PROCEDURES.<br>(a) Each assisted living facility must have written policies and procedures that explain its | A 076 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11968840 | A. BUILDING: _____ B. WING _____ | 03/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND ASSISTED LIVING AND MEMORY CARE | 3339 HWY 17 GREEN COVE SPRINGS, FL 32043 |

| (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 076 | Continued From page 8<br>implementation of state laws and rules relative to ( ). An assisted living facility may not require execution of a as a condition of admission or treatment. The assisted living facility must provide the following to each resident, or resident's representative, at the time of admission:<br>1. Form SCHS- , "Health Care Advance Directives - The Patient's Right to Decide," , , or with a copy of some other substantially similar document, which incorporates information regarding advance directives included in chapter 765, F.S. Form SCHS- is available from the Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 34, Tallahassee, FL 32308 or the agency's website at: http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/HC_Advance_Directives/docs/adv_dir.pdf; and,<br>2. DH Form 1896, Florida Form, , 2004, which is hereby incorporated by reference. This form may be obtained by calling the Department of Health's toll free number 1(800)226-1911, extension 2780 or online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04005.<br>(b) There must be documentation in the resident's record indicating whether a DH Form 1896 has been executed. If a DH Form 1896 has been executed, a yellow copy of that document must be made a part of the resident's record. If the assisted living facility does not receive a copy of a resident's executed DH Form 1896, the assisted living facility must document in the resident's record that it has requested a copy.<br>(c) The executed DH Form 1896 must be readily available to medical staff in the event of an | A 076 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11968840 | A. BUILDING: _____ B. WING _____ | 03/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND ASSISTED LIVING AND MEMORY CARE | 3339 HWY 17 GREEN COVE SPRINGS, FL 32043 |

| (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 076 | Continued From page 9<br><br>emergency.<br>(2) LICENSE REVOCATION. An assisted living facility's license is subject to revocation pursuant to section 408.815, F.S., if, as a condition of treatment or admission, the facility requires an individual to execute or waive DH Form 1896.<br>(3) PROCEDURES. Pursuant to section 429.255, F.S., an assisted living facility must honor a properly executed DH Form 1896 as follows:<br>(a) In the event a resident experiences or , staff trained in , ( ) or a health care provider present in the facility, may withhold ( and ).<br>(b) In the event a resident is receiving hospice services and experiences or , facility staff must immediately contact hospice staff. The hospice procedures take precedence over those of the assisted living facility.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, record review, and interview, the facility failed to ensure resident records contained documentation of code status selection, for 2 of 2 records sampled.<br><br>The findings include:<br><br>Review of the facility census showed Resident 4 was admitted on . Resident 4's record was reviewed on and showed a Demographic sheet in the front. This asked whether the resident executed a ( ), but the Yes/No option was not answered. Photographic evidence obtained. | A 076 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11968840 | A. BUILDING: _____ B. WING _____ | 03/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND ASSISTED LIVING AND MEMORY CARE | 3339 HWY 17 GREEN COVE SPRINGS, FL 32043 |

| (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 076 | Continued From page 10<br><br>The facility census showed Resident 12 was admitted . Resident 12's record showed a demographic sheet which also asked the Yes/No question about whether a had been executed, and it was also not answered. Photographic evidence obtained.<br><br>Resident 12's contract was reviewed which contained an Advanced Directives Policy which stated a request should be made at admission and staff should indicate a copy was requested. Photographic evidence obtained.<br><br>When asked about the process on at 1:15pm, the Wellness Director explained the code status election would be documented in their plan of care (POC). The POC had a box titled "Alerts" with check boxes for either "Full code" or ." The Alerts section was not answered for either Resident 4 or 12 to indicate whether they had an executed or not. Photographic evidence obtained. The Wellness Director reviewed the forms and confirmed the information was missing.<br><br>Class III | A 076 | | |
| A 167 | 59A-36.018 FAC; 429.24 FS Resident Contracts<br><br>59A-36.018 Resident Contracts.<br>(1) Pursuant to section 429.24, F.S., the facility must offer a contract for execution by the resident or the resident's legal representative before or at the time of admission. The contract must contain the following provisions:<br>(a) A list of the specific services, supplies and accommodations to be provided by the facility to the resident, including limited nursing and | A 167 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11968840 | A. BUILDING: _____ B. WING _____ | 03/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND ASSISTED LIVING AND MEMORY CARE | 3339 HWY 17 GREEN COVE SPRINGS, FL 32043 |

| (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 167 | Continued From page 11<br><br>extended congregate care services that the resident elects to receive;<br>(b) The daily, weekly, or monthly rate;<br>(c) A list of any additional services and charges to be provided that are not included in the daily, weekly, or monthly rates, or a reference to a separate fee schedule that must be attached to the contract;<br>(d) A provision stating that at least 30 days written notice will be given before any rate increase;<br>(e) Any rights, duties, or [illegible] of residents, other than those specified in section 429.28, F.S.;<br>(f) The purpose of any advance payments or deposit payments, and the refund policy for such advance or deposit payments;<br>(g) A refund policy that must conform to section 429.24(3), F.S.;<br>(h) A written bed hold policy and provisions for terminating a bed hold agreement if a facility agrees in writing to reserve a bed for a resident who is admitted to a nursing home, health care facility, or [illegible] facility. The resident or responsible party must notify the facility in writing of any change in status that would prevent the resident from returning to the facility. Until such written notice is received, the agreed upon daily, weekly, or monthly rate may be charged by the facility unless the resident's medical condition prevents the resident from giving written notification, such as when a resident is comatose, and the resident does not have a responsible party to act on the resident's behalf;<br>(i) A provision stating whether the facility is affiliated with any religious organization and, if so, which organization and its relationship to the facility;<br>(j) A provision that, upon determination by the administrator or health care provider that the resident needs services beyond those that the | A 167 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11968840 | A. BUILDING: _____ B. WING _____ | 03/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND ASSISTED LIVING AND MEMORY CARE | 3339 HWY 17 GREEN COVE SPRINGS, FL 32043 |

| (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 167 | Continued From page 12<br>facility is licensed to provide, the resident or the resident's representative, or agency acting on the resident's behalf, must be notified in writing that the resident must make arrangements for transfer to a care setting that is able to provide services needed by the resident. In the event the resident has no one to represent him or her, the facility must refer the resident to the social service agency for placement. If there is disagreement regarding the appropriateness of placement, provisions outlined in section 429.26(8), F.S., will take effect;<br>(k) A provision that residents must be assessed upon admission pursuant to subsection 59A-36.006(2), F.A.C., and every 3 years thereafter, or after a significant change, pursuant to subsection (4), of that rule;<br>(l) The facility's policies and procedures for self-administration, assistance with self-administration, and administration of medications, if applicable, pursuant to rule 59A-36.008, F.A.C. This also includes provisions regarding over-the-counter (OTC) products pursuant to subsection (8) of that rule; and,<br>(m) The facility's policies and procedures related to a properly executed DH Form 1896,<br>.<br>(2) The resident, or the resident's representative, must be provided with a copy of the executed contract.<br>(3) The facility may not levy an additional charge for any supplies, services, or accommodations that the facility has agreed by contract to provide as part of the standard daily, weekly, or monthly rate. The resident or resident's representative must be furnished in advance with an itemized written statement setting forth additional charges for any services, supplies, or accommodations available to residents not covered under the | A 167 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11968840 | A. BUILDING: _____ B. WING _____ | 03/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND ASSISTED LIVING AND MEMORY CARE | 3339 HWY 17 GREEN COVE SPRINGS, FL 32043 |

| (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 167 | Continued From page 13<br><br>contract. An addendum must be added to the resident contract to reflect the additional services, supplies, or accommodations not provided under the original agreement. Such addendum must be dated and signed by the facility and the resident or resident's legal representative and a copy given to the resident or resident's representative.<br><br>429.24 FS<br>(1) The presence of each resident in a facility shall be covered by a contract, executed at the time of admission or prior thereto, between the licensee and the resident or his or her designee or legal representative. Each party to the contract shall be provided with a duplicate original thereof, and the licensee shall keep on file in the facility all such contracts. The licensee may not destroy or otherwise dispose of any such contract until 5 years after its expiration.<br><br>(2) Each contract must contain express provisions specifically setting forth the services and accommodations to be provided by the facility; the rates or charges; provision for at least 30 days' written notice of a rate increase; the rights, duties, and of the residents, other than those specified in s. 429.28; and other matters that the parties deem appropriate. A new service or accommodation added to, or implemented in, a resident's contract for which the resident was not previously charged does not require a 30-day written notice of a rate increase. Whenever money is deposited or advanced by a resident in a contract as security for performance of the contract agreement or as advance rent for other than the next immediate rental period:<br>(a) Such funds shall be deposited in a banking institution in this state that is located, if possible, in the same community in which the facility is | A 167 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11968840 | A. BUILDING: _____ B. WING _____ | 03/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND ASSISTED LIVING AND MEMORY CARE | 3339 HWY 17 GREEN COVE SPRINGS, FL 32043 |

| (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 167 | Continued From page 14<br><br>located; shall be kept separate from the funds and property of the facility; may not be represented as part of the assets of the facility on financial statements; and shall be used, or otherwise expended, only for the account of the resident.<br>(b) The licensee shall, within 30 days of receipt of advance rent or a security deposit, notify the resident or residents in writing of the manner in which the licensee is holding the advance rent or security deposit and state the name and address of the depository where the moneys are being held. The licensee shall notify residents of the facility's policy on advance deposits.<br><br>(3)(a) The contract shall include a refund policy to be implemented at the time of a resident's transfer, discharge, or . . .<br>(b) If a licensee agrees to reserve a bed for a resident who is admitted to a medical facility, including, but not limited to, a nursing home, health care facility, or , facility, the resident or his or her responsible party shall notify the licensee of any change in status that would prevent the resident from returning to the facility. Until such notice is received, the agreed-upon daily rate may be charged by the licensee.<br>(c) The purpose of any advance payment and a refund policy for such payment, including any advance payment for housing, meals, or personal services, shall be covered in the contract.<br><br>(4) The contract shall state whether or not the facility is affiliated with any religious organization and, if so, which organization and its general responsibility to the facility.<br><br>(5) Neither the contract nor any provision thereof relieves any licensee of any requirement or | A 167 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11968840 | A. BUILDING: _____ B. WING _____ | 03/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND ASSISTED LIVING AND MEMORY CARE | 3339 HWY 17 GREEN COVE SPRINGS, FL 32043 |

| (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 167 | Continued From page 15<br>imposed upon it by this part or rules adopted under this part.<br><br>(6) In lieu of the provisions of this section, facilities certified under chapter 651 shall comply with the requirements of s. 651.055.<br><br>(7) Notwithstanding the provisions of this section, facilities which consist of 60 or more apartments may require refund policies and termination notices in accordance with the provisions of part II of chapter 83, provided that the lease is terminated automatically without financial penalty in the event of a resident's or relocation due to , hospitalization or to medical reasons which necessitate services or care beyond which the facility is licensed to provide. The date of termination in such instances shall be the date the unit is fully vacated. A lease may be substituted for the contract if it meets the disclosure requirements of this section. For the purpose of this section, the term "apartment" means a room or set of rooms with a kitchen or kitchenette and lavatory located within one or more buildings containing other similar or like residential units.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure 1 of 2 contracts reviewed contained the refund policy.<br><br>The findings include:<br><br>Review of Resident 4's contract showed it was executed on . Nothing in the contract of subsequent addendums included information on the facility's refund policy. Photographic evidence obtained. | A 167 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11968840 | A. BUILDING: _____ B. WING _____ | 03/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND ASSISTED LIVING AND MEMORY CARE | 3339 HWY 17 GREEN COVE SPRINGS, FL 32043 |

| (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 167 | Continued From page 16<br><br>The Administrator stated in an interview at 11:00am on that she would look in her office. At 11:10am on she returned to say she couldn't find it.<br><br>The Executive Assistant stated she would attempt to find it and reviewed Resident 12's contract (which included the refund information) to see where in the refund language may be for Resident 4. At 11:40am on she confirmed the new contract that Resident 4 executed was missing the refund information.<br><br>Class III | A 167 | | |
| A 078 | 59A-36.010(2) FAC Staffing Standards - Staff<br><br>(2) STAFF.<br>(a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership.<br>1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must | A 078 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11968840 | A. BUILDING: _____ B. WING _____ | 03/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND ASSISTED LIVING AND MEMORY CARE | 3339 HWY 17 GREEN COVE SPRINGS, FL 32043 |

| (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 | Continued From page 17<br>submit a health care provider's statement that the individual does not constitute a risk of<br>.<br>2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable<br>.<br>(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 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.<br>(c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C.<br>(d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents.<br>(e) For facilities with a licensed capacity of 17 or more residents, the facility must:<br>1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and,<br>2. Maintain time sheets for all staff.<br>(f) Level 2 background screening must be | A 078 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11968840 | A. BUILDING: _____ B. WING _____ | 03/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND ASSISTED LIVING AND MEMORY CARE | 3339 HWY 17 GREEN COVE SPRINGS, FL 32043 |

| (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 | Continued From page 18 | A 078 | | |

conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S.

This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 2 of 3 sampled employees obtained a statement indicating freedom for communicable , or documentation regarding their status.

The findings include:

Review of the employee record for Employee A, Caregiver, hired , found no evidence of a communicable statement or examination results. The binder these records were held in had a checklist on the cover, and " Results" was not checked off. The checklist did not contain a line regarding a communicable statement. Photographic evidence obtained.

Review of the employee record for Employee B, Caregiver, hired , found no evidence or a communicable statement or examination results. The binder these records were held in had a checklist on the cover, and " Results" was not checked off. The checklist did not contain a line regarding a communicable statement. Photographic evidence obtained.

The Executive Assistant was asked at 11:34am on and she supplied a packet from the Wellness Director's office which employee information. Photographic evidence obtained. The packet had a list of employees who needed "to get their done" and some employees had dates next to their names, and some did not.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11968840 | A. BUILDING: _____ B. WING _____ | 03/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND ASSISTED LIVING AND MEMORY CARE | 3339 HWY 17 GREEN COVE SPRINGS, FL 32043 |

| (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 | Continued From page 19<br><br>Employee A had a notation that she needed to get a ,; Employee B did not have a date, just a circle with a line. The packet contained several forms clipped together and there were no testing results or communicable statements located for Employees A or B.<br><br>The Wellness Director was asked about and Communicable information on at 2:08pm. She confirmed the missing information but said she would verify whether the Administrator had this information.<br><br>At 3:35pm on the Administrator confirmed the facility needed to revise their /Communicable documentation and nothing was able to be provided to show Employees A and B had the required forms.<br><br>Class III | A 078 | | |