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
	AL11966171	A. BUILDING: _____ B. WING _____	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VISTA AT HAMMOCK COVE	5175 TAMIAMI TRAIL EAST NAPLES, FL 34113

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A 000	Initial Comments An unannounced Change of Ownership, emergency power plan monitoring, health facility reporting system, visitation form, and complaint survey for complaints #2024000074, #2024000512, #2024005475, #2025001184, & #2025002778 was conducted on through at The Vista at Hammock Cove, an assisted living facility in Naples, Florida. Complaint #2024000074 was not substantiated. Complaint #2024000512 was substantiated without deficient practice. Complaint #2024005475 was not substantiated. Complaint #2025001184 had two allegations, one was not substantiated, one was substantiated at A0093. Complaint #2025002778 was not substantiated. The following is a description of the deficiencies: .	A 000		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers.	A 052		

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A 052	Continued From page 1 (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube	A 052		

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A 052	Continued From page 2 inserted in a , of the body. (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with	A 052		

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A 052	Continued From page 3	A 052		

self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed.
(c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container.
(d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record.
(e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed:
1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility,
2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record,
3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or
4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging.
(f) Assistance with self-administration of

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A 052	Continued From page 4 medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure staff who assist with self-administration of medications follow proper procedure for 1 (Resident #14) of 3 residents sampled for medication observation. The findings included: Policy: ASSISTING WITH ROUTINE MEDICATIONS. POLICY: Staff shall assist residents with the administration of routine medications in a manner according to established procedures. PROCEDURES: 1. The trained staff assisting with medication should: Read the information regarding the medication in the resident' medication record (i.e., the medication name, dosage and time the medication is to be taken) out loud to the resident. Read the medication label (i.e., the medication name, dosage and time the medication is to be taken). Health Assessment Form (1823) review for Resident #14 dated indicated Resident	A 052		

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A	Continued From page 5 #14 needed assistance with self administration of medication. On at 11:45 a.m., Staff G was observed preparing Resident #14 medications. Staff G removed the required dosage and placed them in a plastic cup, and mixed the medications with chocolate pudding. Staff G approached resident #14 in her room, and said to Resident #14 "can you please get up so I can give you your noon medications?". Staff G was observed saying "here are your pills." Staff G then told Resident#14 to open her , and spoon fed the medications into Resident #14 . Staff G acknowledged she is not a licensed nurse. Staff G said she has been working here for close to a month and she did not know if the facility had medication waivers or not. Staff G also said she did not think they needed to tell the residents in the memory unit the names of the medications being given. On at 12:56 p.m., during an interview the Administrator acknowledged that the residents in the facility did not have any mediation waivers and staff G was required to the residents the names and dosages of the medications being given. The Administrator acknowledged staff G was not a licensed nurse. The facility Administrator acknowledged on at 3:00 p.m. that staff G did not follow proper procedure when assisting Resident #14 with self administration of medications. Class III .	A 052		

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

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A 078	Continued From page 7 responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility ◡ to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure all staff submit a written statement within 30 days after beginning employment, from a health care provider, documenting that the individual does not have any signs of communicable , and documented evidence of documentation of freedom from ( ) on an annual basis thereafter, for 2 (Staff A, Staff B) of 3 records reviewed. The findings included:	A 078		

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A 078	Continued From page 8 On , a review of Licensed Practical Nurse (LPN) Staff A record revealed a hire date of . There was no evidence of documentation of a written statement form a healthcare provider indicating Staff A was free of communicable . On , a review of Medication Technician (MT) Staff B record revealed a hire date of . There was no evidence of documentation of a written statement form a healthcare provider indicating Staff B was free of communicable , and no documentation of freedom from annually thereafter . On at 10:00 a.m., during an interview, the Executive Director (ED), the Senior Asset Care Manager, and the Business Manager. The ED said that all of the documentation they have had been supplied. They acknowledged that the facility failed to provide the necessary documentation of status and freedom of communicable for staff. The ED acknowledged that this was deficient practice. Class III .	A 078		
A 081 SS=E	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee	A 081		

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A 081	Continued From page 9	A 081		

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) 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

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A 081	Continued From page 10	A 081		

orientation prior to interacting with residents.
(c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record.
(d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover:
1. Resident's rights; and,
2. The facility's license type and services offered by the facility.
(3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff:
(a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , may be used to meet this requirement.
(b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects:
1. Reporting adverse incidents.
2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation.
(c) Staff who provide direct care to residents, who

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A 081	Continued From page 11 have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures.	A 081		

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A 081	Continued From page 12 This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure all direct care employees completed 3 hours of Activities of Daily Living (ADL) training, 1 hour of training for Facility Emergency Procedures training, Resident Rights/Reporting or Neglect training, and completion of Elopement Response training for 3 (Executive Director, Staff A, Staff B) of 3 records reviewed. The findings included: On , a review of LPN Staff A record revealed a hire date of . There was no documentation for completion of Elopement Response Training, 1 hour of Facility Emergency Procedures training, and or 1 hour of Resident Rights/Recognizing or Neglect training in the file for LPN Staff A. On , a review of MT Staff B record revealed a hire date of . There was no documentation of completion of 3 hours of Activities of daily living (ADL) and Behavioral needs Training in the file for MT Staff B. On , a review of the Executive Director (ED) record revealed a hire date of . There was no documentation of completion of Elopement Response Training based on the facility policies and procedures in the file for the ED. On , at 10:00 a.m., during an interview, the Senior Asset Care Director said they were working on the training's and are putting a new system in place. The ED said that the previous	A 081		

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A 081	Continued From page 13 owner kept some of the training documentation and threw away or shredded some of the employee documentation. The ED acknowledged that all of the training documentation were not in place for the existing employees. The ED acknowledged the deficiencies in the required staff training. Class III .	A 081		
A 082 SS=D	59A-36.011(4) FAC Training - / (4) . / . . . (/ ´). Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on and , including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure all employees completed a one-time course on and for 1 (Staff B) of 3 records reviewed. The findings included: On , a review of MT Staff B record revealed a hire date of . There was no evidence of documentation of completion of / . training in the file for Staff B.	A 082		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 082	Continued From page 14 On , at 10:00 a.m., during an interview, the Senior Asset Care Director said they were working on the trainings and are putting a new system in place. The ED said that the previous owner kept some of the trainings and threw away or shredded some of the employee documentation. The ED acknowledged all of the trainings were not in place for the existing employees. Class III	A 082		
A 090 SS=D	59A-36.011(11) FAC Training - (11) TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that all Administrators, managers, direct care staff, and admissions personnel receive 1 hour of training based on the facility policeis and	A 090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966171	A. BUILDING: _____ B. WING _____	04/15/2025

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A 090	Continued From page 15 procedures for 2 (Executive Director, Staff A) of 3 records reviewed. On , a record review of the Executive Director (ED) file revealed a hire date of . There was no evidence of completion of documentation of Training based on the facility policies and procedures in the file. On , a record review of Licensed Practical Nurse (LPN) Staff A file revealed a hire date of . There was no evidence of completioin of documentation of training based on the facility policies and procedures in the file. On , at 10:00 a.m., during an interview, the Senior Asset Care Director said that they were working on the trainings and are putting a new system in place. The ED said that the previous owner kept some of the trainings and threw away or shredded some of the employee documentation. The ED acknowledged that all of the trainings were not in place. Class III .	A 090		
A 093 SS=E	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at:	A 093		

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	AL11966171	A. BUILDING: _____ B. WING _____	04/15/2025

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A 093	Continued From page 16 http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the	A 093		

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	AL11966171	A. BUILDING: _____ B. WING _____	04/15/2025

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A 093	Continued From page 17	A 093		

seasonal availability of fresh produce or the preferences of the residents.
(d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months.
(e) Therapeutic diets must be prepared and served as ordered by the health care provider.
1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility.
2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal.
(f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals.
(g) Food must be served attractively at safe and

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	AL11966171	A. BUILDING: _____ B. WING _____	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 093	Continued From page 18	A 093		

palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on .
(h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority.

This Statute or Rule is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to offer snacks at least once daily as required. The facility failed to ensure the printed and approved menu is being followed and any changes are being documented on the substitution log for 100% of residents.

The findings included:

1. Observation on st 9:30 a.m. revealed a hydration station in the facility's main lobby area. Further observation at both memory units showed that there was hydration stations with water at both memory units. No snacks observed.

During observation at 10:10 a.m., the Assistant Dining Director (ADD) said snacks are to be offered at 10:00 a.m. and 2:00 p.m. The ADD confirmed there were no snacks offered at the time of the observation.

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	AL11966171	A. BUILDING: _____ B. WING _____	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VISTA AT HAMMOCK COVE	5175 TAMIAMI TRAIL EAST NAPLES, FL 34113

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A 093	Continued From page 19 On at 10:44 a.m., during an interview, Caregiver Staff E said they're supposed to offer snacks at 11:00 am and 2:00 p.m. Staff E said she did not see any snacks offered to residents. On at 10:49 a.m., during an interview, Caregiver Staff F said they used to provide snacks two times a day, but since the new owner took over they stopped and she did not know why. On at 10:50 a.m., during an interview, the Memory Unit Activities Director said they just had water and no snacks at 10:00 a.m. because no one from the dietary services department brought it in. On at 11:00 a.m., during an interview, Caregiver Staff G said she has been working here for close to a month and never saw a snack provided to residents. On at 11:05 a.m., during an interview, Licensed Practical Nurse Staff C said that for the week she has been working here she never saw any snacks offered to residents. On at 11:08 a.m., during an interview, Caregiver Staff H said they used to offer snacks 2 times a day, but it stopped months ago when the new owner took over. On at 11:10 a.m., during an interview, Caregiver Staff I said they used to offer snacks 2 times a day, but it stopped months ago when the new owner took over. On at 11:24 a.m., during an interview, Resident #4 said she has been here for almost a year and she was never offered snacks.	A 093		

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	AL11966171	A. BUILDING: _____ B. WING _____	04/15/2025

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THE VISTA AT HAMMOCK COVE	5175 TAMIAMI TRAIL EAST NAPLES, FL 34113

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A 093	Continued From page 20 On at 1:00 p.m., during an interview, the Assistant Dietary Director (ADD) and the Administrator acknowledged no snacks were offered to the residents in the memory unit. They said there was a disconnect in assignments and the staff was not aware of who's responsibility it was to prepare and deliver the snacks to the residents in the 2 memory units. They also said they offered coffee and water to residents in the main AL. They said they did not offer snacks because some of the rooms had kitchenettes. Review of facility room list revealed: There are a total of 117 rooms; 60 out of the 117 rooms were identified as having kitchenettes; 33 out the those 60 rooms were vacant; 57 rooms without kitchenettes were occupied and did not receive snacks as required. The ADD said they used to put snacks out and residents "went shopping" emptying the tray in minutes. On at 7:30 a.m. during an interview, the Dietary Director, the ADD, and Operations , confirmed that residents in the memory unit and main AL did not receive snacks daily as required. They said they were supposed to offer snacks 2 times a day at 10:00 a.m. and to 2:00 p.m. On at 3:00 p.m., during an interview, the Administrator acknowledged that facility did not provide snacks as required. 2. Menu review of lunch on shows that Broccoli Cheese Soup, Cheese Quesadilla, Grilled Ham and Cheese Sandwich, Spanish Rice, Fresh Tomato Salsa and a Baked Roll was	A 093		

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A 093	Continued From page 21 on the written menu. **Photograph on File** On , at 11:30 a.m., during observation of lunch service, residents in memory care were served sliced chicken, mashed potatoes and braised greens. **Photograph on File** Review of the substitution log on showed no changes to the menu were documented. On , at 1:30 p.m., during an interview, the Assistant Dining Director (ADD) said that there were no substitution logs for at least 6 months, there are no substitution logs in place. The ADD said that Memory Care has the same menu as the Main Dining Room and the printed menu is the correct menu. The ADD stated, "I asked the cook who replied that he made chicken, potatoes and greens for the Memory Care unit". The ADD acknowledged the menu was not being followed for lunch on . On , at 8:00 a.m., during an interview, the Dietary Director stated, "The menu needs to be followed at all times, and any substitutions need to be documented in the substitution log." Class III .	A 093		

Agency for Health Care Administration

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	AL11966171	A. BUILDING: _____ B. WING _____	04/15/2025

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CZ830 SS=E	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 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	CZ830		

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	AL11966171	A. BUILDING: _____ B. WING _____	04/15/2025

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THE VISTA AT HAMMOCK COVE	5175 TAMIAMI TRAIL EAST NAPLES, FL 34113

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CZ830	Continued From page 1	CZ830		

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 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

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	AL11966171	A. BUILDING: _____ B. WING _____	04/15/2025

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CZ830	Continued From page 2 approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to timely submit the Comprehensive Emergency Management Plan (CEMP). The findings included: On , during record review, the date of the most recent CEMP approval was documented on , with an expiration date of . There was no submission documentation in the record after . On at 8:55 p.m., during an interview, the Executive Director (ED) said that the previous Executive Director was working on the CEMP but not sure about submission. She had no documentation of submission. On , at 9:30 a.m., during a phone interview, the Collier County Emergency Services division confirmed no correspondence between of 2024 and of 2025 in regard to the CEMP for either Barrington Terrace or The Vista at Hammock Cove. On at 10:35 a.m., during an interview, the ED acknowledged that the facility was deficient in the process of CEMP submission. .	CZ830		
CZ875 SS=E	430.5025(4 &) / ; Training	CZ875		

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	AL11966171	A. BUILDING: _____ B. WING _____	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VISTA AT HAMMOCK COVE	5175 TAMIAMI TRAIL EAST NAPLES, FL 34113

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CZ875	Continued From page 3 (4) Employees of covered providers must complete the following training for and related forms of : (a) Upon beginning employment, each employee must receive basic written information about interacting with persons who have or related forms of . (b) Within 30 days after beginning employment, each employee who provides personal care to or has regular contact with participants, patients, or residents must complete a 1-hour training program provided by the department. 1. The department shall provide training that is available online at no cost. The 1-hour training program shall contain information on understanding the basics about the most common forms of , how to identify the signs and symptoms of , and skills for communicating and interacting with persons with 's or related forms of . A record of the completion of the training program must be made available to the covered provider which identifies the training curricula, the name of the employee, and the date of completion. 2. A covered provider must maintain a record of the employee's completion of the training program and, upon written request of the employee, provide the employee with a copy of the record of completion consistent with the employer's written policies. 3. An employee who has completed the training required in this subsection is not required to repeat the program upon changing employment to a different covered provider. (c) Within 7 months after beginning employment for a home health agency, nurse registry, or companion or homemaker service provider, each employee who provides personal care must	CZ875		

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THE VISTA AT HAMMOCK COVE	5175 TAMIAMI TRAIL EAST NAPLES, FL 34113

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CZ875	Continued From page 4 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 or related forms of , in addition to the training specified in paragraphs (a) and (b), employees must receive the following training: 1. Within 3 months after beginning employment, each employee who provides personal care to or has regular contact with the residents or participants must complete the additional 3 hours of training as provided in paragraph (d). 2. Within 6 months after beginning employment, each employee who provides personal care must complete an additional 4 hours of -specific training. Such training must include, but is not limited to, understanding and related forms of , the stages of , communication strategies, medical information, and stress management.	CZ875		

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THE VISTA AT HAMMOCK COVE	5175 TAMIAMI TRAIL EAST NAPLES, FL 34113

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CZ875	Continued From page 5 3. Thereafter, each employee who provides personal care must participate in at least 4 hours of continuing education each calendar year through contact hours, on-the-job training, or electronic learning . For this subparagraph, the term "on-the-job training" means a form of direct coaching in which a facility administrator or his or her designee instructs an employee who provides personal care with guidance, support, or -on experience to help develop and refine the employee's skills for caring for a person with or a related form of . The continuing education must cover at least one of the topics included in the -specific training in which the employee has not received previous training in the previous calendar year. The continuing education may be fulfilled and documented in a minimum of one quarter-hour increments through on-the-job training of the employee by a facility administrator or his or her designee or by an electronic learning chosen by the facility administrator. On-the-job training may not account for more than 2 hours of continuing education each calendar year. (f)1. An employee provided, assigned, or referred by a health care services pool must complete the training required in paragraph (c), paragraph (d), or paragraph (e) that is applicable to the covered provider and the position in which the employee will be working. The documentation verifying the completed training and continuing education of the employee, if applicable, must be provided to the covered provider upon request. 2. A health care services pool must verify and maintain documentation as required under s. 400.980(5) before providing, assigning, or referring an employee to a covered provider. (7) For a certified nursing assistant as defined in	CZ875		

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	AL11966171	A. BUILDING: _____ B. WING _____	04/15/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ875	Continued From page 6 s. 464.201, training hours completed as required under this section may count toward the total hours of training required to maintain certification as a nursing assistant. (8) For a health care practitioner as defined in s. 456.001, training hours completed as required under this section may count toward the total hours of continuing education required by that practitioner's licensing board. (9) Each person employed, , or referred to provide services before , , , must complete the training required in this section before , . . Proof of completion of equivalent training completed before , . , shall substitute for the training required in subsection (4). Each person employed, , or referred to provide services on or after , . , may complete training using approved curriculum under paragraph (5)(d) until the effective date of the rules adopted by the department under subsection (6). This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure all staff completed the necessary training to satisfy 430.5205 F.A.C. " and Related Forms of Education and Training Act" for 2 (Staff A, Staff B) of 3 records reviewed. The findings included: On , a review of Licensed Practical Nurse (LPN) Staff A record revealed a hire date of . There was no evidence of completion of 1 hour of (ADRD) training from the Department of Elder Affairs (DOEA), 3 hours of and Related Level I training, and 4 hours of and	CZ875		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966171	A. BUILDING: _____ B. WING _____	04/15/2025

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CZ875	Continued From page 7 Related Level II training in the employee record for Staff A. On , a review of Medication Technician (MT) Staff B record revealed a hire date of . There was no evidence of completion of1 hour of (ADRD) training from the Department of Elder Affairs (DOEA). Further review revealed evidecn of a certificate of completion for 4 hours of Training on . The training was not completed within 3 months of the date of hire. There was no evidence of completion of 4 hours of and Related Level II training in the record for Staff B. On , at 10:00 a.m., during an interview, the Senior Asset Care Director said they were working on the trainings and are putting a new system in place. The ED said that the previous owner kept some of the trainings and threw away or shredded some of the employee documentation. The ED acknowledged that all of the trainings were not in place for the existing employees. The administrators acknowledged the deficiencies in staff training. Class III .	CZ875		