

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/09/2025
NAME OF PROVIDER OR SUPPLIER SAVANNAH COTTAGE OF OVIEDO			STREET ADDRESS, CITY, STATE, ZIP CODE 445 ALEXANDRIA BLVD. OVIEDO, FL 32765		
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CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the are enrolled in the national retained print notification program at the Federal Bureau of Investigation: 1. A person with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. 2. Effective , or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity. (c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse. 1. Before , initial status and any changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person ' s status has been made. 2. Effective , initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person ' s status has been made.	CZ814			

AHCA Form 3020-0001

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

TITLE

(X6) DATE

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CZ814	Continued From page 1 (d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic submission to the Department of Law Enforcement. The registration must include the person's full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review, review of the Care Provider Background Screening Clearinghouse and interview, the facility failed to update the clearinghouse within 5 business days after 1 of 11 sampled staff (A) was hired. Findings: Review of caregiver A's personnel record revealed a hire date of On at 2:05PM, a review of the care provider background screening clearinghouse revealed caregiver A was not listed. On at 9:57AM, the business office manager confirmed the findings and said she did not add caregiver A because the facility was in the process of changing emails due to a change of ownership.	CZ814			

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CZ814	Continued From page 2 Unclassified A 000 Initial Comments A complaint investigation (2025006146) and generator monitoring were conducted at Savannah Cottage of Oviedo on _____ and _____. The facility had deficiencies at the time of the survey. A Class I deficiency was found A0030 Resident - Care Rights and Procedures The facility failed to honor resident rights when _____ () was performed on a sampled residents who had a _____ (). A Class I deficiency was found A0076 Do No _____ Orders (DNORs) The facility failed to honor resident rights when _____ () was performed on a sampled residents who had a _____ (). The facility's Administrator/CEO was notified of the Class I noncompliance on _____ at 9:32 AM. The census at the start of the survey was 33 The following is a description of the deficiencies found at the time of the visit.	CZ814 A 000			

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A 030 A 030 SS=J	Continued From page 3 59A-36.007(5) FAC; 429.28() FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the	A 030 A 030			

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A 030	Continued From page 4 facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and : 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1) (d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State	A 030			

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A 030	Continued From page 5 of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from _____ and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when	A 030			

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A 030	Continued From page 6 prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making . . . for health care services, the provision of or arrangement of transportation to health care . . . and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally . . . , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.	A 030			

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A 030	Continued From page 7 (1) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without _____, interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, _____, and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder _____ Hotline operated by the Department of Children and Families, and, if applicable, _____, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder _____ Hotline operated by the Department of Children and Families, and _____, Rights Florida.	A 030		

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A 030	Continued From page 8 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated or under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to honor resident rights when () was performed on 1 of 18 sampled residents who had a () #1. Findings: Review of resident #1's record revealed a facility admission date of . The record contained a . On the resident was admitted to hospice services.	A 030			

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A 030	Continued From page 9 On at 9:35 AM, the memory care director documented that at approximately 2:05 AM the resident was observed with cessation of breath. The resident was last seen during midnight rounds. The hospice was notified and pronounced resident at 2:36 AM. On at 9:42 AM, caregiver A said she was employed four days ago. She said a resident 's were maintained in the nurse's station. She said she was certified. She was not trained in the policy. She said based on her experience she would not perform on a resident who had a . She would contact hospice for a resident who received those services. On at 11:37 AM, caregiver B said that on at approximately 2 AM she entered resident #1's room and found the resident pale and not breathing. The caregiver called the Memory Care Director, who said the resident was a "full code" and instructed the caregiver to perform . The caregiver said she called out to caregiver D to call 911 then she started while the resident was in bed. Caregiver D responded to the room with the automated external defibrillator (). Caregiver B applied the electrode pads and the defibrillator gave instructions to begin . Emergency medical services () arrived and took over. Caregiver B said her supervisor caregiver C arrived and told caregiver B the resident had a . By that time had the resident on a stretcher. Caregiver C provided the , so they put the resident in bed. The Resident Care Director also arrived and instructed caregiver B to write a statement about the incident. Caregiver B said	A 030			

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A 030	Continued From page 10 the resident's _____ was not on the wall above the resident's bed, like it was in the other two buildings. Caregiver B said the _____ was also in each resident's chart that was stored in the nurse's station. When caregiver B was asked why she didn't check the resident's chart for a _____, she responded that at the time she was thinking only about helping the resident and did not want to leave her. The caregiver said she last checked on the resident at approximately 12:00 AM and the resident was breathing. Caregiver B stated she later learned the Memory Care Director said she (caregiver B) told her it was resident #1's roommate who was unresponsive. Caregiver B said that was not true, that she knew the difference between the two residents. Caregiver B said besides writing her statement, no training was given and the _____ policy was not discussed with her following the incident. On _____ at 12:17 PM, the Resident Care Director said on _____, she received a call from caregiver C who informed her _____ was being performed on resident #1. The Resident Care Director said she told caregiver C to check the resident's chart to verify the existence of a _____. Caregiver C reported there was a _____. The Resident Care Director instructed caregiver C to take the _____ to the resident's room and stop _____. The Resident Care Director said she was trained on the facility's _____ policy when she worked at a sister facility. She said the policy was that if a resident had a _____, they did not perform _____ and if they received Hospice, notify them. She said resident _____ were kept in their chart in the nurse's station. On _____ at 12:50 PM, caregiver E checked	A 030			

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A 030	Continued From page 11 each resident room to observe the sign above the bed. She said a red dot sticker meant the resident had a _____, blue and yellow stickers meant hospice, and green meant full code so do _____. On _____ at 1:15 PM, caregiver E said she received training on the _____ policy. She said the policy is to honor a _____. If on hospice, they are called first. She said a _____ is in the resident's chart and in a book on medication carts C and D. She said the Memory Care Director educated her on Friday _____ by telling her to honor a _____ and by having her watch a mini video and take a quiz. On _____ at 1:20 PM, the Memory Care Director said she did not give training to caregiver E because she did not work on Friday's. On _____ at 1:25 PM, caregiver E stated she made a mistake when she said the Memory Care Director educated her on Friday. The caregiver said the Memory Care Director told her on Friday only to do an annual _____ training video (she did not do the training.) The caregiver said the Administrator and the Resident Care Director always brought up a _____ during staff meetings that were held every six months. On _____ at 1:35 PM, the Memory Care Director now said she did work on _____ for work unrelated to the incident and while here she told caregiver E to remember the signs above resident beds and to make sure everyone was on the same page. On _____ at 3 PM, caregiver C said she was in	A 030			

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A 030	Continued From page 12 a different building on the night of the incident. She received a call from caregiver D telling her resident #1 was unresponsive. Caregiver C called the Resident Care Director, who said she was pretty sure the resident was on hospice and had a . Caregiver C responded to the memory care building and confirmed the existence of a . She then gave it to . EMS stopped doing . Caregiver C said the Resident Care Director came to the facility and told staff to first check the chart for a and if there was, do not perform . Caregiver C said the policy was if a resident was on hospice, they were to be called first and if there was a , do not perform . She said no additional training was given following the incident. On at 3:46 PM, the Memory Care Director said the sign above the beds was implemented three to four days prior to this incident. She had no procedure for checking them for accuracy and no procedure to check if they're present and not removed by a resident. She said she trained caregiver B on the signs prior to the incident but did not document it. The Memory Care Director did not remember the last time she read the policy but knew for sure not since the incident. She was not aware of the sticker color inconsistency in the policy and said she'll have to buy orange and black stickers now. She said when caregiver B called her that night the caregiver said the name of resident #1's roommate when she reported a resident was unresponsive. The Memory Care Director said she knew the roommate did not have a which was why she told the caregiver to perform . When asked what measures were put in place to prevent reoccurrence, she replied that	A 030			

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A 030	Continued From page 13 the Administrator and the Resident Care Director were investigating the incident. She then said she was not aware of anything new being done. She said a sign with a red sticker was on the wall above resident #1's bed on the night of the incident. On at 4:29 PM, caregiver B said there was nothing on the wall that night. She said she spoke with the Memory Care Director earlier today, who said the red sticker was on the wall that night. Caregiver B said that was not true. Additionally, no one ever told her the meaning of the stickers. The undated advanced directives and policy indicated advanced directive desires are honored by the facility. It is the policy to call 911 in an emergency, provide the advance directives to the emergency personnel and allow them to make any decisions. An orange and black sticker " " will be placed in the front inside and inside of the resident chart. Also, a "yellow dot" will be placed on the , of the resident chart. Resident medical files will be audited periodically and randomly and findings documented at a minimum every 6 months to ensure ongoing compliance with the policy. Training will be done upon hire and on an annual basis. The name and signature of the presenter will be included on the in-service sheet. Documentation of class attendance will include the title or subject of the in-service, the date and time, duration, and names and signatures of attendees. If the resident is enrolled in hospice, the director of resident care, nurse or lead person on duty will notify hospice. On at 4:50 PM, the Business Office	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/09/2025
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SAVANNAH COTTAGE OF OVIEDO

**445 ALEXANDRIA BLVD.
OVIEDO, FL 32765**

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A 030	Continued From page 14 Manager provided a different advanced directives policy. This policy, revised indicated a copy of the _____ will be placed in the resident's file and in their room. A list of all residents with a current valid _____ will be available in the following locations (nothing was documented in this space.) _____ should immediately be presented with the residents' On _____ at 11:18 AM, the Memory Care Director was asked why she did not document all the details in her _____ note about the incident, including that _____ was performed. She replied that she did not think all those details had to be in the note. On _____ at 12:00 PM, the Administrator stated the memory care director called her the night of the incident and said resident #1's roommate coded and _____. The Administrator stated the Memory Care Director said 911 was called and _____ was started. The Administrator said the Memory Care Director called her _____ and said it was resident #1 who _____. The Administrator responded by saying _____ should not have been done because resident #1 had a _____. When asked what the facility did to prevent recurrence, the administrator said the signs with stickers were put above the resident beds prior to the current incident. On _____ at 12:27 PM, the Resident Care Director did not remember if she saw a red sticker on resident #1's wall when she responded to the incident. Class I	A 030		

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A 076 SS=J	59A-36.009 FAC () (1) POLICIES AND PROCEDURES. (a) Each assisted living facility must have written policies and procedures that explain its 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: 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, 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. (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	A 076			

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A 076	Continued From page 16 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. (c) The executed DH Form 1896 must be readily available to medical staff in the event of an emergency. (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. (3) PROCEDURES. Pursuant to section 429.255, F.S., an assisted living facility must honor a properly executed DH Form 1896 as follows: (a) In the event a resident experiences _____ or _____, staff trained in _____ () or a health care provider present in the facility, may withhold _____ () and _____). (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. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to honor resident rights when _____ () was performed on 1 of 18 sampled residents who had a _____ () #1. Findings: Review of resident #1's record revealed a facility	A 076			

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A 076	Continued From page 17 admission date of _____. The record contained a _____. On _____ the resident was admitted to hospice services. On _____ at 9:35 AM, the memory care director documented that at approximately 2:05 AM the resident was observed with cessation of breath. The resident was last seen during midnight rounds. The hospice was notified and pronounced resident _____ at 2:36 AM. On _____ at 9:42 AM, caregiver A said she was employed four days ago. She said a resident _____'s were maintained in the nurse's station. She said she was _____ certified. She was not trained in the _____ policy. She said based on her experience she would not perform _____ on a resident who had a _____. She would contact hospice for a resident who received those services. On _____ at 11:37 AM, caregiver B said that on _____ at approximately 2 AM she entered resident #1's room and found the resident pale and not breathing. The caregiver called the Memory Care Director, who said the resident was a "full code" and instructed the caregiver to perform _____. The caregiver said she called out to caregiver D to call 911 then she started while the resident was in bed. Caregiver D responded to the room with the automated external defibrillator (_____) Caregiver B applied the _____ electrode pads and the defibrillator gave instructions to begin _____. Emergency medical services (_____) arrived and took over. Caregiver B said her supervisor caregiver C arrived and	A 076			

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A 076	Continued From page 18 told caregiver B the resident had a . By that time had the resident on a stretcher. Caregiver C provided the , so they put the resident in bed. The Resident Care Director also arrived and instructed caregiver B to write a statement about the incident. Caregiver B said the resident's was not on the wall above the resident's bed, like it was in the other two buildings. Caregiver B said the was also in each resident's chart that was stored in the nurse's station. When caregiver B was asked why she didn't check the resident's chart for a , she responded that at the time she was thinking only about helping the resident and did not want to leave her. The caregiver said she last checked on the resident at approximately 12:00 AM and the resident was breathing. Caregiver B stated she later learned the Memory Care Director said she (caregiver B) told her it was resident #1's roommate who was unresponsive. Caregiver B said that was not true, that she knew the difference between the two residents. Caregiver B said besides writing her statement, no training was given and the policy was not discussed with her following the incident. On at 12:17 PM, the Resident Care Director said on , she received a call from caregiver C who informed her was being performed on resident #1. The Resident Care Director said she told caregiver C to check the resident's chart to verify the existence of a . Caregiver C reported there was a . The Resident Care Director instructed caregiver C to take the to the resident's room and stop . The Resident Care Director said she was trained on the facility's policy when she worked at a sister facility. She said the policy	A 076			

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A 076	Continued From page 19 was that if a resident had a _____, they did not perform _____ and if they received Hospice, notify them. She said resident _____ were kept in their chart in the nurse's station. On _____ at 12:50 PM, caregiver E checked each resident room to observe the sign above the bed. She said a red dot sticker meant the resident had a _____, blue and yellow stickers meant hospice, and green meant full code so do _____. On _____ at 1:15 PM, caregiver E said she received training on the _____ policy. She said the policy is to honor a _____. If on hospice, they are called first. She said a _____ is in the resident's chart and in a book on medication carts C and D. She said the Memory Care Director educated her on Friday _____ by telling her to honor a _____ and by having her watch a mini video and take a quiz. On _____ at 1:20 PM, the Memory Care Director said she did not give training to caregiver E because she did not work on Friday's. On _____ at 1:25 PM, caregiver E stated she made a mistake when she said the Memory Care Director educated her on Friday. The caregiver said the Memory Care Director told her on Friday only to do an annual _____ training video (she did not do the training.) The caregiver said the Administrator and the Resident Care Director always brought up a _____ during staff meetings that were held every six months. On _____ at 1:35 PM, the Memory Care Director now said she did work on _____ for _____.	A 076		

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A 076	Continued From page 20 work unrelated to the incident and while here she told caregiver E to remember the signs above resident beds and to make sure everyone was on the same page. On at 3 PM, caregiver C said she was in a different building on the night of the incident. She received a call from caregiver D telling her resident #1 was unresponsive. Caregiver C called the Resident Care Director, who said she was pretty sure the resident was on hospice and had a . Caregiver C responded to the memory care building and confirmed the existence of a . She then gave it to . EMS stopped doing . Caregiver C said the Resident Care Director came to the facility and told staff to first check the chart for a and if there was, do not perform . Caregiver C said the policy was if a resident was on hospice, they were to be called first and if there was a , do not perform . She said no additional training was given following the incident. On at 3:46 PM, the Memory Care Director said the sign above the beds was implemented three to four days prior to this incident. She had no procedure for checking them for accuracy and no procedure to check if they're present and not removed by a resident. She said she trained caregiver B on the signs prior to the incident but did not document it. The Memory Care Director did not remember the last time she read the policy but knew for sure not since the incident. She was not aware of the sticker color inconsistency in the policy and said she'll have to buy orange and black stickers now. She said when caregiver B called her that night the caregiver said the name of resident #1's	A 076		

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A 076	Continued From page 21 roommate when she reported a resident was unresponsive. The Memory Care Director said she knew the roommate did not have a _____ which was why she told the caregiver to perform _____. When asked what measures were put in place to prevent reoccurrence, she replied that the Administrator and the Resident Care Director were investigating the incident. She then said she was not aware of anything new being done. She said a sign with a red sticker was on the wall above resident #1's bed on the night of the incident. On _____ at 4:29 PM, caregiver B said there was nothing on the wall that night. She said she spoke with the Memory Care Director earlier today, who said the red sticker was on the wall that night. Caregiver B said that was not true. Additionally, no one ever told her the meaning of the stickers. The undated advanced directives and policy indicated advanced directive desires are honored by the facility. It is the policy to call 911 in an emergency, provide the advance directives to the emergency personnel and allow them to make any _____ decisions. An orange and black sticker " _____ " will be placed in the front inside and _____ inside of the resident chart. Also, a "yellow dot" will be placed on the _____ of the resident chart. Resident medical files will be audited periodically and randomly and findings documented at a minimum every 6 months to ensure ongoing compliance with the policy. Training will be done upon hire and on an annual basis. The name and signature of the presenter will be included on the in-service sheet. Documentation of class attendance will include the title or subject of the in-service, the date and	A 076			

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A 076	Continued From page 22 time, duration, and names and signatures of attendees. If the resident is enrolled in hospice, the director of resident care, nurse or lead person on duty will notify hospice. On at 4:50 PM, the Business Office Manager provided a different advanced directives policy. This policy, revised , indicated a copy of the will be placed in the resident's file and in their room. A list of all residents with a current valid will be available in the following locations (nothing was documented in this space.) should immediately be presented with the residents' On at 11:18 AM, the Memory Care Director was asked why she did not document all the details in her note about the incident, including that was performed. She replied that she did not think all those details had to be in the note. On at 12:00 PM, the Administrator stated the memory care director called her the night of the incident and said resident #1's roommate coded and . The Administrator stated the Memory Care Director said 911 was called and was started. The Administrator said the Memory Care Director called her and said it was resident #1 who . The Administrator responded by saying should not have been done because resident #1 had a . When asked what the facility did to prevent recurrence, the administrator said the signs with stickers were put above the resident beds prior to the current incident.	A 076			

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A 076	Continued From page 23 On at 12:27 PM, the Resident Care Director did not remember if she saw a red sticker on resident #1's wall when she responded to the incident. Class I	A 076			
A 077 SS=G	429.176 FS: 429.52(), 59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010	A 077			

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A 077	Continued From page 24 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least _____; 2. If employed on or after _____, have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to _____, are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the _____ of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility	A 077			

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A 077	Continued From page 25 administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference	A 077			

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A 077	Continued From page 26 and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility's administrator failed to effectively manage all staff and the provision of appropriate care to all residents by failing to ensure resident rights were honored when _____ was performed on 1 of 18 sampled residents who had a (1,) by failing to ensure the advanced directives and _____ policies were followed, by failing to ensure the _____ policies contained all required information, by failing to ensure the _____ was valid for 1 of 18 sampled residents (18,) by failing to ensure 1 of 11 sampled staff (C) received at least one hour of training in the facility's policy and procedures regarding within 30 days after employment, and by failing to ensure the Care Provider Background Screening Clearinghouse was updated within 5 business days after 1 of 11 sampled staff (A) was hired. Findings: The administrator's job description, dated _____, indicated, among other things, the administrator was responsible for managing day-to-day functions of the community, including but not limited to resident care services. Performs various supervisor duties to ensure efficiency and quality of operations. 1. Review of resident #1's record revealed a facility admission date of _____.	A 077			

Agency for Health Care Administration

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A 077	Continued From page 27 The record contained a On the resident was admitted to hospice services. On at 9:35 AM, the memory care director documented that at approximately 2:05 AM the resident was observed with cessation of breath. The resident was last seen during midnight rounds. The hospice was notified and pronounced the resident at 2:36 AM. On at 9:42 AM, caregiver A said she was employed four days ago. She said a resident 's were maintained in the nurse's station. She said she was certified. She was not yet trained in the policy. She said based on her experience she would not perform on a resident who had a . She would contact a hospice for a resident who received those services. On at 11:37 AM, caregiver B said that on at approximately 2 AM she entered resident #1's room and found the resident pale and not breathing. The caregiver called the memory care director, who said the resident was a "full code" and instructed the caregiver to perform . The caregiver said she called out to caregiver D to call 911 then she started while the resident was in bed. Caregiver D responded to the room with the automated external defibrillator (). Caregiver B applied the electrode pads and the defibrillator gave instructions to begin . Emergency medical services () arrived and took over. Caregiver B said her supervisor caregiver C arrived and told caregiver B the resident had a . By	A 077		

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A 077	Continued From page 28 that time had the resident on a stretcher. Caregiver C provided the , so they put the resident in bed. The resident care director also arrived and instructed caregiver B to write a statement about the incident. Caregiver B said the resident's was not on the wall above the resident's bed, like it was in the other two buildings. Caregiver B said the was also in each resident's chart that was stored in the nurse's station. When the agency for healthcare administration (AHCA) surveyor asked the caregiver why she didn't first check the resident's chart for a , she responded that at the time she was thinking only about helping the resident and did not want to leave her. Caregiver B said she did not know the resident received Hospice. The caregiver said she received training on the facility's policies on , which indicated was not to be done. The caregiver said she did not know the resident received hospice services. She did not recall what or if the policy addressed what to do when a resident received Hospice. The caregiver said she last checked on the resident at approximately 12 AM and the resident was breathing. The caregiver said she later learned the memory care director said the caregiver told her it was resident #1's roommate who was unresponsive. The caregiver said that was not true, that she knew the difference between the two residents. The caregiver said that besides writing her statement, no training was given and the policy was not discussed with her following the incident. On at 12:17 PM, the resident care director said that on she received a call from caregiver C who informed her was being performed on resident #1. The resident care director said she told caregiver C to check	A 077			

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A 077	Continued From page 29 the resident's chart to verify the existence of a . Caregiver C reported there was a . The resident care director instructed caregiver C to take the to the resident's room and stop . The resident care director said she was trained on the facility's policy when she worked at a sister facility. She said the policy was that if a resident had a , they did not perform and if they received Hospice, notify them. She said resident were kept in their chart in the nurse's station. When asked what steps the facility took to prevent recurrence, she said the memory care director posted a sign above each resident's bed with either a green sticker (okay to do) or a red sticker (has , do not do). She said the other steps were to write up the memory care director and caregivers B and C (not done yet) and educate the staff on what entails, the process you take for and to first check status. She said the will be placed in the resident's nightstand. She said a resident's status is also on the electronic medication observation record (MOR.) She said that after receiving the call she came to the facility and unofficially educated caregivers B and D on where the is in a chart and to check there first then communicate the findings with their co-worker over the walkie talkie. She said an all-staff meeting will be scheduled within the next week. When asked how the facility will follow-up and evaluate the effectiveness of these measures, she responded "we could do mock drills to make sure staff know what to do. We can stop staff and ask random questions about what they would do in this instance." On at 12:50 PM, caregiver E accompanied the surveyor to each resident room	A 077			

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A 077	Continued From page 30 to see the sign above the bed. She said a red dot sticker meant the resident had a , blue and yellow stickers meant hospice, and green meant full code so do . The findings were: #9 had a but no sign and no sticker. #10 had a but no sign and no sticker. #11 was on hospice but no sign and no sticker. #12 had a but had a green sticker. #13 had a and received hospice services but no sign and no stickers. #14 did not have a but no sign and no sticker. #15 had a but had a green sticker. #16 was on hospice but no sticker. #17 did not have a but no sticker. #18 was on hospice but no sticker. On at 1:15 PM, caregiver E said she received training on the policy. She said the policy is to honor a . If on hospice, they are called first. She said a is in the resident's chart and in a book on medication carts C and D. She said the memory care director educated her on Friday by telling her to honor a and by having her watch a mini video and take a quiz. On at 1:20 PM, the memory care director said she did not give training to caregiver E because she did not work on Friday's. On at 1:25 PM, caregiver E approached the AHCA surveyor and said she made a mistake when she said the memory care director educated her on Friday. The caregiver said the memory care director told her on Friday only to do an annual training video (she did not do the training.) The caregiver said the	A 077		

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A 077	Continued From page 31 administrator and the resident care director always brought up honoring a during staff meetings that were held every six months. On at 1:35 PM, the memory care director now said she did work on for work unrelated to the incident and while here she told caregiver E to remember the signs above resident beds and to make sure everyone was on the same page. On at 3 PM, caregiver C said she was in a different building on the night of the incident. She received a call from caregiver D telling her resident #1 was unresponsive. Caregiver C called the resident care director, who said she was pretty sure the resident was on hospice and had a . Caregiver C responded to the memory care building and confirmed the existence of a . She then gave it to . EMS stopped doing . Caregiver C said the resident care director came to the facility and told staff to first check the chart for a and if there was, do not perform . Caregiver C said the policy was if a resident was on hospice, they were to be called first and if there was a , do not perform . She said no additional training was given following the incident. On at 3:46 PM, the memory care director said the sign above the beds was implemented three to four days prior to this incident. She had no procedure for checking them for accuracy and no procedure to check if they're present and not removed by a resident. She said she trained caregiver B on the signs prior to the incident but did not document it. The memory care director did not remember the last time she read the	A 077		

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A 077	Continued From page 32 policy but knew for sure not since the incident. She was not aware of the sticker color inconsistency in the policy and said she'll have to buy orange and black stickers now. She said when caregiver B called her that night the caregiver said the name of resident #1's roommate when she reported a resident was unresponsive. The memory care director said she knew the roommate did not have a which was why she told the caregiver to perform . When asked what measures were put in place to prevent reoccurrence, she replied that the administrator and the resident care director were investigating the incident. She then said she was not aware of anything new being done. She said a sign with a red sticker was on the wall above resident #1's bed on the night of the incident. On at 4:29 PM, caregiver B said there was nothing on the wall that night. She said she spoke with the memory care director earlier today, who said the red sticker was on the wall that night. Caregiver B said that was not true. Additionally, no one ever told her the meaning of the stickers. The undated advanced directives and policy indicated advanced directive desires are honored by the facility. It is the policy to call 911 in an emergency, provide the advance directives to the emergency personnel and allow them to make any decisions. An orange and black sticker " " will be placed in the front inside and inside of the resident chart. Also, a "yellow dot" will be placed on the , of the resident chart. Resident medical files will be audited periodically and randomly and findings documented at a minimum every 6 months to	A 077			

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A 077	Continued From page 33 ensure ongoing compliance with the policy. Training will be done upon hire and on an annual basis. The name and signature of the presenter will be included on the in-service sheet. Documentation of class attendance will include the title or subject of the in-service, the date and time, duration, and names and signatures of attendees. If the resident is enrolled in hospice, the director of resident care, nurse or lead person on duty will notify hospice. On at 4:50 PM, the business office manager provided a different advanced directives policy. This policy, revised indicated a copy of the will be placed in the resident's file and in their room. A list of all residents with a current valid will be available in the following locations (nothing was documented in this space.) should immediately be presented with the residents' . This policy did not contain a provision that if a resident received hospice services and experienced or , facility staff must immediately contact hospice staff. The hospice procedures take precedence over those of the assisted living facility. It did not include the procedures currently used to identify those residents with a and those on hospice. On at 11:18 AM, the memory care director was asked why she did not document all the details in her note about the incident, including that was performed. She replied that she did not think all those details had to be in the note. On at 12 PM, the administrator said the memory care director called her the night of the incident, said the name of resident #1's	A 077			

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A 077	Continued From page 34 roommate then said the resident . The memory care director said 911 was called and was started. The memory care director called the administrator and said it was resident #1 who . The administrator responded by saying should not have been done because resident #1 had a . When asked what the facility did to prevent recurrence, the administrator said the signs with stickers were put above resident beds after being previously cited in 2023 for a similar incident. She said the book with was created and put in the medication carts because of this incident. She said the plan was to put the on the of the resident's door and do training with all memory care staff. When asked why these things have not been done yet, she replied "it just happened a week ago." She went on to say the resident care director was going to schedule staff meetings and she believed all were copied and will be put on the doors by the end of today. She and the resident care director talked about choosing random staff to question and determine their knowledge of the requirements. This has not been done yet. When she asked the process to check the signs and stickers in the rooms for accuracy and to ensure they weren't pulled down by residents, she said the memory care director was responsible for that. She said the caregivers were responsible for telling the memory care director a sign was removed. She said the undated policy was from the first management company. She said the one given by the business office manager was the correct one. The findings regarding the policies were discussed with her. On at 12:27 PM, the resident care director did not remember if she saw a red	A 077			

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A 077	Continued From page 35 sticker on resident #1's wall when she responded to the incident. Review of resident #18's revealed the power of attorney's (POA) name was where the resident's name should be. The resident's name was nowhere on the form, making it invalid. On at 4 PM, the memory care director confirmed the findings and said no one saw the error. She said she will get the POA to sign a new one. Review of caregiver C's personnel record revealed she was hired on . The record did not include documentation to indicate the caregiver received at least one hour of training in the facility's policy and procedures regarding within 30 days after employment. On at 4:54pm, the findings were discussed with the business office manager, who said caregiver C was assigned to the training but has not yet completed it. Review of caregiver A's personnel record revealed a hire date of . On at 2:05pm, review of the care provider background screening clearinghouse revealed caregiver A was not listed. On at 9:57am, the business office manager confirmed the findings and said she did not add caregiver A because the facility was in the process of changing emails due to a change of ownership. Class II	A 077			

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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 personnel record review and interview, the facility failed to ensure 1 of 11 sampled staff (C) received at least one hour of training in the facility's policy and procedures regarding () within 30 days after employment. Findings: Review of caregiver C's personnel record revealed she was hired on . The record did not include documentation to indicate the caregiver received at least one hour of training in the facility's policy and procedures regarding within 30 days after employment. On at 4:54pm, the findings were discussed with the business office manager, who said caregiver C was assigned the training but	A 090			

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A 090	Continued From page 37 has not yet completed it. Class III	A 090			