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
	AL11968041	A. BUILDING: _____ B. WING _____	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TROY & GREG CORP	12260 SW 184TH ST MIAMI, FL 33177

(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 000	Initial Comments A complaint survey for complaint # 2025006922 was conducted on through at Troy & Greg Corp, in Miami, Florida. Troy & Greg Corp was not in compliance with the regulations.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of	A 025		

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A 025	Continued From page 1 resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain a general awareness and provided supervision for two (1, and 3) out of six sampled residents' whereabouts. Resident #1 who eloped and was found by a police officer and was transported to the hospital by emergency medical services for further observation. The facility failed to maintain a written record, updated as needed, of any significant changes for Resident #1. Findings: 1)	A 025		

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A 025	Continued From page 2 A review of the police reported dated documented: "This unit responded to the intersection of SW 122nd Avenue and SW 184th Street (in emergency mode) in reference a disoriented elderly male seen ˬ the area alone. It was advised by an anonymous reporting person. Upon arrival, this unit contacted another [Resident #1], who advised his name but an inaccurate date of birth. [Fire rescue] arrived and had [Resident #1] transported to the [hospital] for medical care. While conducting an area canvas, this unit and [police officer], was able to locate the original location to be [address]. This unit and [officer] observed the front door ajar; upon announcing ourselves, we contacted the caretaker [Staff B]. She advised this unit that she was taking a shower when [Resident #1] left the assisted living facility. She was unaware as to how he managed to obtain the keys to the front door or how long he had gone from ALF. It is to be noted that this is the second time police have responded to the listed location in reference to a missing and/or ˬ elderly patient this year." Interviewed on at 8:37 PM Staff B (Caregiver) stated that she was working alone, and she went to take a shower around 7:30 PM on . Staff B stated further that when she came out of the shower, Resident #1 was gone. However, the police report for calls for service by address dated showed the police was dispatched at 8:30 PM more than an hour later. A review of Resident #1's hospital records dated documented: "This a ˬ male with known found sitting on a bus bench by police department and brought him by . His ALF stated that he from	A 025		

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A 025	Continued From page 3 their facility, and they wanted him to be worked up. Medical decision: ." Interviewed on at 10:54 AM Staff C (Caregiver) when asked if she worked on Saturday, , Staff C stated that the last time she worked was on that Friday, . Staff C stated that she returned to work on Tuesday, . Staff C stated that she does not know what specifically happened and even they (employees) don't know what happened. Staff C stated, "He might have escaped through the door." Interviewed on at 9:02 PM the Owner stated that they did not find him, but it was the police. A review of the staffing pattern for Saturday, , showed Staff B was not on schedule to work and the Administrator was scheduled from 7:00 PM to 7:00 AM. However, the Administrator did not work and there was no one listed on the schedule to replace her on the shift. A review of Resident #1's health assessment with a completion date of showed , , , , Prostatic Hyperplasia ( ), 's , , ( ), A review of Resident #1's progress notes showed no documentation of his elopement, transport and hospitalization on . Interviewed on at 9:47 PM the Owner stated that he was going to get everything done. 2)	A 025		

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A 025	Continued From page 4 A review of the police report for calls of service by address dated showed police was dispatch for a missing resident. Interviewed on at 10:54 AM when asked if any resident was missing in of 2025, Staff C stated, "[Resident #3]." Staff C stated further that he left because he did not like the food. Staff C stated, "He walked out the front and went two houses down. I called the police because he did not want to come in." When asked if she worked alone, Staff C stated, "Yes." A review of Resident #3's progress notes showed no documentation of resident leaving facility and police being called. The facility's & elopement policy and procedures states: "There are many types of interventions that can be used to aid in the prevention of and elopement. One of the most basic preventive measures is employee awareness." Interviewed on at 12:06 PM the Administrator acknowledged that there were issues. Class II	A 025		
A 027 SS=D	59A-36.007(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making , , and remind residents about scheduled , , for medical, dental, nursing, or mental health	A 027		

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A 027	Continued From page 5 services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation. (c) The facility may not require residents to receive services from a , health care provider. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to make arrangement for health care for Resident #1 after discharge from hospital. Findings: A review of Resident #1's hospital records dated showed a follow with his primary care physician within one to two days. Interviewed on at 12:56 PM when asked if he saw Resident #1 yet, the primary care physician stated that he had not seen Resident #1 and was not scheduled to see him. Interviewed on at 12:06 PM the Administrator acknowledged that there were issues. Class III	A 027		
A 030 SS=E	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 030		

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A 030	Continued From page 6 (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 facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and	A 030		

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A 030	Continued From page 7 , ; 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 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	A 030		

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A 030	Continued From page 8 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 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.	A 030		

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A 030	Continued From page 9 (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. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the	A 030		

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A 030	Continued From page 10 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. 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	A 030		

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A 030	Continued From page 11 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 observations and interviews the facility failed to maintain the resident bill of rights. A Staff member kept their personal items in residents' room interfering with the use of the closet in resident living quarters. Resident rights were not provided for two out of six residents (resident #4 and 5). Finding included: Observation on at 8:35pm in # 's closet Staff B (caretaker) kept personal items including clothing, a dresser, shoes, and medications. Resident #4 and 5 reside in the room where Staff B items are being kept. Interview on at 8:35pm Staff B stated that the items in the closet are private and belong to her. She was concerned that the medications found were going to get her in trouble. Class III	A 030		

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A 032	Continued From page 12	A 032		
A 032 SS=G	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the	A 032		

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A 032	Continued From page 13 resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to identify one (#1) out of six sampled residents as an elopement risk. Resident #1 eloped on and was found in the street on a bus bench by police and transported to hospital by emergency medical services. The facility failed to ensure one (#1) out of six sampled residents who eloped have identification on their person that includes his name, the facilities name and address and telephone number after an elopement. The facility failed to identify elopement risks and	A 032		

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	AL11968041	A. BUILDING: _____ B. WING _____	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TROY & GREG CORP	12260 SW 184TH ST MIAMI, FL 33177

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A 032	Continued From page 14 Findings: 1) A review of the police reported dated documented: "This unit responded to the intersection of SW 122nd Avenue and SW 184th Street (in emergency mode) in reference a disoriented elderly male seen ˬ the area alone. It was advised by an anonymous reporting person. Upon arrival, this unit contacted another [Resident #1], who advised his name but an inaccurate date of birth. [Fire rescue] arrived and had [Resident #1] transported to the [hospital] for medical care. While conducting an area canvas, this unit and [police officer], was able to locate the original location to be [address]. This unit and [officer] observed the front door ajar; upon announcing ourselves, we contacted the caretaker [Staff B]. She advised this unit that she was taking a shower when [Resident #1] left the assisted living facility. She was unaware as to how he managed to obtain the keys to the front door or how long he had gone from ALF. It is to be noted that this is the second time police have responded to the listed location in reference to a missing and/or ˬ elderly patient this year." A review of Resident #1's hospital records dated documented: "This a ˬ male with known found sitting on a bus bench by police department and brought him by . His ALF stated that he from their facility, and they wanted him to be worked up. Medical decision: ." Interviewed on at 8:37 PM Staff B (Caregiver) stated that Resident #1 left the house when she went to take a shower around 7:30 PM.	A 032		

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A 032	Continued From page 15 Interviewed on at 12:56 PM the primary care physician stated that Resident #1 used to be homeless and that he used to walk the streets and wanted to go ack to his country. The PCP stated further that Resident #1 was an elopement risk before he was admitted to the facility. Interviewed on at 2:34 PM the Department and Children and Families investigator stated that Resident #1 was found by police and disoriented. The investigator stated that the police took him to the facility and found the door ajar and met Staff B (Caregiver) there. When asked if Resident #1 eloped in the past, the investigator stated that he stated that he did not know but mentioned Resident #3 elopement last year. Observation on at 8:30 PM found no facility and or lanyard on Resident 1's person with its name and address and telephone number. Interviewed on at 9:02 PM, the Owner stated that Resident #1 was only gone for 15 minutes. The Owner stated, "we did not find him. The police found him. We don't have a with facility's identification on Resident because he does not have a history of elopement." A review of Resident #1's health assessment with a completion date of showed 's ( ), (OA). The resident's physical limitations showed an unsteady gait. The status showed alert. The nursing requirements showed as needed. The resident had precautions. The resident was not listed	A 032		

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A 032	Continued From page 16 as an elopement risk. The activities of daily living showed independent with ambulation, eating, and needed supervision with _____, self-care, toileting, transferring, and assistance with bathing. 2) A review of the police report for calls of service by address dated showed police was dispatch for a missing resident. Interviewed on at 10:54 AM when asked if any resident was missing in , Staff C stated, "[Resident #2]." Staff C stated further that he left because he did not like the food. Staff C stated, "He walked out the front and went two houses down. I called the police because he did not want to come in." When asked if she worked alone, Staff C stated, "Yes." A review of the facility's records found only one elopement drill conducted in 2024. 2) Interviewed on at 2:25 PM the Case Manager for Resident #1 stated that another resident eloped before. Interviewed on at 2:24 PM the investigator stated that Resident #3 eloped from the facility in 2024. Interviewed on at 12:06 PM the Administrator acknowledged that there were issues. The facility's risk assessment elopement policy states: "Questions we asked at our facility in order to assess the resident for risk of elopement is:	A 032		

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A 032	Continued From page 17 1. Is the resident independently mobile? 2. Is the resident ˬ ˏ ˎ ? 3. Does the resident have competent decision-making capability? 4. Does the resident ? 5. Does the resident have exit seeking behavior? 6. Is there a past history of ˬ or existing a home or facility without the needed supervision? 7. Has the resident asked questions about the facility's rule about leaving the facility? 8. Has the resident exhibiting hostile behavior that shows that he or she may leave the facility without permission? Answering yes to any one of these questions or a combination of them can identify the resident at risk for ˬ and potential elopement." The facility's resident ˬ & elopement policy and procedures states: "In addition to employees' awareness, physical preventive measures including door alarms, automatic door locking systems, and guard bracelets, will be considered. Visual deterrents such as stop signs or environmental camouflage, which often works well with residents, will also be considered." Class II	A 032		
A 055 SS=F	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage	A 055		

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A 055	Continued From page 18 residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by	A 055		

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A 055	Continued From page 19 being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness.	A 055		

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A 055	Continued From page 20 (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to keep centrally stored medications locked for six out of six residents (#1, 2, 3, 4 and 5). Findings included: Observation on at 8:41pm showed the medication cabinet was unlocked. The cabinet contained medication for the facilities residents in bin (Photographic evidence obtained). Interview on at 8:42pm Staff B (caretaker) asked why the cabinet was open, did not answer. However, she stated that the "owner would be there soon." Observation on at 8:46pm showed Staff B retrieved the MOR from the unlocked cabinet when asked for the record. Class III	A 055		
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	A 077		

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A 077	Continued From page 21 requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all 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.;	A 077		

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A 077	Continued From page 22 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to , , are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if 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	A 077		

Agency for Health Care Administration

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A 077	Continued From page 23 other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that it was under the supervision of an Administrator who provided appropriate care for all residents (#1, 2, 3, 4, 5, & 6). The administrator failed to investigate Resident #1, Resident #2's, and Resident #3's elopement. The administrator failed to be aware of and informed about a disturbance that occurred at the facility, which required a police presence. The Administrator failed to	A 077		

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A 077	Continued From page 24 account for who was working when Resident #1 eloped. Findings: 1) Interviewed on at 12:56 PM the primary care physician (PCP) stated that Resident #1 used to be homeless and that he used to walk the streets and wanted to go to his country. The PCP stated further that Resident #1 was an elopement risk before he was admitted to the facility. The PCP stated that he has yet to see [Resident #1] since elopement on . A review of the police report showed Resident #1 eloped on . Interviewed on at 2:06 PM when asked if Resident #1 eloped before, the Administrator stated, "No." A review of Resident #1's health assessment dated showed a diagnosis of , , . However, the resident was not listed as an elopement risk. 2) A review of the police report for calls of service by address dated showed police was dispatch for a missing resident. Interviewed on at 10:54 AM when asked if any resident was missing in , Staff C stated, "[Resident #2]." Staff C stated further that he left because he did not like the food. Staff C stated, "He walked out the front and went two houses down. I called the police because he did not want to come in." Interviewed on at 2:06 PM when	A 077		

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A 077	Continued From page 25 asked about the missing person on , the Administrator stated that she did not know anything about a missing person on . 3) A review of the police report for calls of service by address dated showed police were called for a disturbance. Interviewed on /2:06 PM when asked about a disturbance on , the Administrator stated, "No recollections and that was why she has not reported it." 4) Interviewed on at 2:34 PM the investigator stated that Resident #3 eloped last year. Interviewed on at 2;26 PM when asked if Resident #3 eloped before, the Administrator stated, "No." 5) Interviewed on at 8:37 PM when asked who was working on Saturday, , , when Resident #1 left the house, Staff B (Caregiver) stated that she was working. When asked if she worked alone that day, Staff B stated, "Yes." When asked if she was on schedule to work, Staff B stated, "Somebody (Staff C Caregiver) else was sick since Friday [ ]." Interviewed on at 2:06 PM when asked how she found out about the incident, the Administrator stated, "The only information I got was from one employee and from the Owner." The Administrator stated that there was supposed to be another employee working that day. The	A 077		

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A 077	Continued From page 26 Administrator stated Staff C left early before the incident and came the same night. When informed that she (Administrator) was on the schedule to work with Staff C, the Administrator stated, "I can't account for the staffing." Interviewed on at 10:54 AM when asked if she worked on Saturday, , , , Staff C stated that the last time she worked was on that Friday, , . Staff C stated that she returned to work on Tuesday, , . Interviewed on at 12:06 PM the Administrator acknowledged that there were issues. Class II	A 077		
A 152 SS=E	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable	A 152		

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A 152	Continued From page 27 to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observations and interviews the facility failed to keep its premises free of hazards. Staff medications were found in an area accessible to residents. Findings Included: Observation on at 8:35pm in Resident #4 and 5 room's (#) closet Staff B (caretaker) kept personal items including medications in a clear zipper bag on top of the dresser. The closet was not locked and only a curtain separated the closet space from the room. Resident #4 and Resident 5 reside in the room where the unlocked staff medications were found. (photographic evidence obtained) Interview on at 8:35pm Staff B stated that she had just taken the medication out and	A 152		

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A 152	Continued From page 28 was concerned that this was going to get her in trouble. Class III	A 152		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C.	A 162		

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A 162	Continued From page 29 (f) A ⌄ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their ⌄ recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that ⌄ not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , ( ), CF-ES 1006, , which is hereby incorporated by reference	A 162		

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A 162	Continued From page 30 and available for review at: http://www.flrules.org/Gateway/reference.asp?No =Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively.	A 162		

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A 162	Continued From page 31 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure and maintain a complete health assessment for Resident #4. The facility failed to update Residents #1, and 3 health as elopement risk after elopement, police involvement and hospitalization. Findings: 1) A review of Resident #4's health assessment with a completion date of showed section two was left unchecked and there was no indication whether she needed assistance with self-administration, needs medication administrator or able to self-administer medications. 2) A review of the police report for calls of service by address dated showed police was dispatch for a missing resident. Interviewed on at 10:54 AM when asked if any resident was missing in , of 2025, Staff C stated, "[Resident #3]." Staff C stated further that he left because he did not like the food. Staff C stated, "He walked out the front and went two houses down. I called the police because he did not want to come in." When asked if she worked alone, Staff C stated, "Yes." However, a review of Resident #3's health assessment with a completion date of showed he was not listed as an elopement risk. Interviewed on at 12:56 PM the primary care physician stated that Resident #1 used to be homeless and that he used to walk the	A 162		

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A 162	Continued From page 32 streets and wanted to go ack to his country. The PCP stated further that Resident #1 was an elopement risk before he was admitted to the facility. A review of Resident #1's health assessment with a completion date of showed , , , and 's . . . . . . The resident had precautions. The resident was not listed as an elopement risk. Interviewed on at 9:47 PM the Owner stated that he was going to take care of the problem. Interviewed on at 12:06 PM the Administrator acknowledged that there were issues. Class III	A 162		
A 165 SS=F	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means:	A 165		

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A 165	Continued From page 33 (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415.	A 165		

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A 165	Continued From page 34 (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on interview and record review the facility failed to report adverse incidents with the Internal risk management and quality assurance program. The facility failed to provide within 1 day a	A 165		

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A 165	Continued From page 35 preliminary report to the agency for one out of six residents (Resident #1) and failed to report to the agency for three out of six residents. (#1, 2 and, 3) Findings included: A review of records showed that there was no adverse incident presented in Adverse Incident Report System (AIRS) as of since for facility. An Interview on at 8:30pm with Staff B(caretaker) shows that Resident #1 left the facility and was brought by police. An Interview on at 8:48pm with Staff D (owner) confirmed that Resident #1 was found by the sheriff department on . Furthermore, when asked why the incident had not been reported to the agency, the owner stated that it slipped his mind (translated from Spanish), and that Resident #1 was missing for so little time. A review of the record of the Police Call-for-Service log showed three (3) calls for service from , to , . To wit, 2025 at 8:30pm "Investigation" (case number PD250517145301); at 4:06 pm "Disturbance"; and at 12:10pm "Missing Person." An interview on 10:58am with Staff C (caretaker) showed that she was aware of an incident in of 2025 involving Resident #2. Staff C called police to get Resident #2 " to the house." An interview on at 2:50pm from	A 165		

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A 165	Continued From page 36 another State Agency's investigator stated that there was another elopement in 2024 involving Resident #3. A review of records Police report dated Case No PD250517145301 shows that Police responded to an anonymous complaint of a "disoriented elderly man the area alone" at 8:33pm on . A police investigation was conducted and identified the elderly person as Resident #1. Still pictures of police bodycam showed Resident#1 sitting on a bus bench being evaluated by emergency medical services ( ). Report stated that Resident #1 was transported to the hospital for evaluation. The report stated that police canvased the area and located the facility with the front door ajar. Report stated that the police contacted Staff B. An interview on 2:03pm with the Administrator showed that the administrator was aware of the incident with Resident #1 and acknowledge not reporting the incident in AIRS. She stated that the resident was only missing for a short while and was found close by. When asked how she knew that it was a short while she said that the Staff D and Staff B told her. When asked if Staff D was at the facility that night, she said no. She denied any knowledge of any other incidents prior to . She denied any knowledge of any incidents involving police calls in 2024 and 2025. Class III	A 165		
AL241 SS=D	429.075( ); 59A-36.020(2) FAC LMH - Records 429.075	AL241		

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AL241	Continued From page 37 (3) A facility that has a limited mental health license must: (a) Have a copy of each mental health resident's community living support plan and the , agreement with the mental health care services provider or provide written evidence that a request for the community living support plan and the , agreement was sent to the Medicaid managed care plan or managing entity under contract with the Department of Children and Families within 72 hours after admission. The support plan and the agreement may be combined. (b) Have documentation provided by the department that each mental health resident has been assessed and determined to be able to live in the community in an assisted living facility that has a limited mental health license or provide written evidence that a request for documentation was sent to the department within 72 hours after admission. (c) Make the community living support plan available for inspection by the resident, the resident's legal guardian or health care surrogate, and other individuals who have a lawful basis for reviewing this document. (d) Assist the mental health resident in carrying out the activities identified in the resident's community living support plan. (4) A facility that has a limited mental health license may enter into a , agreement with a private mental health provider. For purposes of the limited mental health license, the private mental health provider may act as the case manager. 59A-36.020 (2) RECORDS. (a) A facility with a limited mental health license	AL241		

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AL241	Continued From page 38 must maintain an up-to-date admission and discharge log containing the names and dates of admission and discharge for all mental health residents. The admission and discharge log required in rule 59A-36.015, F.A.C., satisfies this condition provided that all mental health residents are clearly identified. (b) Staff records must contain documentation that designated staff have completed limited mental health training as required by rule 59A-36.011, F.A.C. (c) Resident records must include: 1. Documentation, provided by a mental health care provider within 30 days of the resident's admission to the facility, that the resident is a mental health resident as defined in section 394.4574, F.S., and that the resident is receiving social security , or supplemental security income and , as follows: a. An affirmative statement on the Alternate Care Certification for , , ( ) form, CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-03988, that the resident is receiving SSI or SSDI due to a mental , b. Written verification provided by the Social Security Administration that the resident is receiving SSI or SSDI for a mental . Such verification may be acquired from the Social Security Administration upon obtaining a release from the resident permitting the Social Security Administration to provide such information, or c. A written statement from the resident's case manager or other mental health care provider that the resident is an adult with severe and persistent mental . The case manager or other	AL241		

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AL241	Continued From page 39 mental health care provider must consider the following minimum criteria in making that determination: (I) The resident is eligible for, is receiving, or has received mental health services within the last 5 years, or (II) The resident has been diagnosed as having a severe or persistent mental . 2. An appropriate placement assessment provided by the resident's mental health care provider within 30 days of admission to the facility that the resident has been assessed and found appropriate for residence in an assisted living facility. Such assessment must be conducted by a psychiatrist, clinical psychologist, clinical social worker, , , nurse, or an individual supervised by one of these professionals. a. Any of the following documentation that contains the name of the resident and the name, signature, date, and license number, if applicable, of the person making the assessment, meets this requirement: (I) Completed Alternate Care Certification for , , , ( ) form, CF-ES Form 1006, (II) Discharge Statement from a state mental hospital completed no more than 90 days before admission to the assisted living facility provided it contains a statement that the individual is appropriate to live in an assisted living facility, or (III) Other signed statement that the resident has been assessed and found appropriate for residency in an assisted living facility. b. A mental health resident returning to a facility from treatment in a hospital or crisis stabilization unit will not be considered a new admission and will not require a new assessment. However, a break in a resident's residency that requires the facility to execute a new resident contract or	AL241		

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AL241	Continued From page 40 admission agreement will be considered a new admission and the resident's mental health care provider must provide a new assessment. 3. A Community Living Support Plan. Each mental health resident and the resident's mental health case manager must, in consultation with the facility administrator, prepare a plan within 30 days of the resident's admission to the facility or within 30 days after receiving the appropriate placement assessment in paragraph (2)(c), whichever is later, that: a. Includes the specific needs of the resident that must be met in order to enable the resident to live in the assisted living facility and the community, b. Includes the clinical mental health services to be provided by the mental health care provider to help meet the resident's needs, and the frequency and duration of such services, c. Includes any other services and activities to be provided by or arranged for by the mental health care provider or mental health case manager to meet the resident's needs, and the frequency and duration of such services and activities, d. Includes the ˬ of the facility to facilitate and assist the resident in attending . . and arranging transportation to . . for the services and activities identified in the plan that have been provided or arranged for by the resident's mental health care provider or case manager, e. Includes a description of other services to be provided or arranged by the facility, f. Includes a list of factors pertinent to the care, safety, and welfare of the mental health resident and a description of the signs and symptoms , to the resident that indicate the immediate need for professional mental health services, g. Is in writing and signed by the mental health	AL241		

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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
AL241	Continued From page 41 resident, the resident's mental health case manager, and the assisted living facility administrator or manager and a copy placed in the resident's file. If the resident refuses to sign the plan, the resident's mental health case manager must add a statement that the resident was asked but refused to sign the plan, h. Is updated at least annually or if there is a significant change in the resident's behavioral health, i. , include the , Agreement described in subparagraph (2)(c)4. If included, the mental health care provider must also sign the plan; and, j. Must be available for inspection to those who have legal authority to review the document. 4. , Agreement. The mental health care provider for each mental health resident and the facility administrator or designee must prepare a written statement, within 30 days of the resident's admission to the facility or receipt of the resident's appropriate placement assessment, whichever is later. The statement: a. Provides procedures and directions for accessing emergency and after-hours care for the mental health resident. The provider must furnish the resident and the facility with the provider's 24-hour emergency crisis telephone number; b. Must be signed by the administrator or designee and the mental health care provider, or by a designated representative of a Medicaid prepaid health plan if the resident is on a plan and the plan provides behavioral health services in section 409.912, F.S.; c. , cover all mental health residents of the facility who are clients of the same provider; and, d. , be included in the Community Living Support Plan described in subparagraph (2)(c)3.	AL241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968041	A. BUILDING: _____ B. WING _____	05/30/2025

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AL241	Continued From page 42 5. Missing documentation will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the appropriate party. A documented request for such missing documentation made by the facility administrator within 72 hours of the resident's admission will be considered a good faith effort. The documented request must include the name, title, and phone number of the person to whom the request was made and must be kept in the resident's file. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility with a mental health license failed to maintain an up-to-date admissions and discharge log with the names and dates of admission and discharge for all (#1, and 2) mental health residents. The facility failed to ensure Residents #1 and 2 had an annual and updated community living support plan and , agreement in their files. Findings: Observation on at 8:30 PM found residents #1 and 2 in the facility. A review of the Admissions and Discharge log showed no indication that Residents #1 and 2 were mental health residents. A review of Resident #1's records showed the last community support plan and , agreement in file was dated . A review of Resident #2's records showed the last community living support plan and , agreement in file was dated .	AL241		

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
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AL241	Continued From page 43 Interviewed on at 9:47 PM the Owner acknowledged that Residents #1 and 2 were mental health residents but stated that he would have to get their plans done. The Owner stated further, "I need to put it here!" The Owner stated that he had two mental health residents on the admissions and discharge log. The Owner concluded that he was going to get it done. Interviewed on at 12:06 PM the Administrator acknowledged that there were issues. Class III	AL241		