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
	AL11969409	A. BUILDING: _____ B. WING _____	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS SENIOR LIVING AT SARASOTA	5750 HONORE AVENUE SARASOTA, FL 34233

(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 An unannounced relicensure, extended congregate care, emergency power plan monitoring, generator form, visitation form and complaint survey for #2024008617 and #2025002079 was conducted at Angels Senior Living at Sarasota on through . Deficiencies were identified at the time of survey.	A 000		
A 025 SS=E	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,	A 025		

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A 025	Continued From page 1 including the following: (a) Monitoring of the quantity and quality of 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 provide adequate supervision to 2 (Residents #11, #3) of 3 residents reviewed, in providing appropriate and timely care services. This puts residents in need of care unable to obtain required assistance. The findings included: 1. Review of Resident #11's health record showed that he was admitted to the facility on . His Health Assessment (Form 1823)	A 025		

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A 025	Continued From page 2 showed that he had a diagnosis of and required three times weekly on Monday, Wednesday, and Friday. His activities of daily living (ADL) needs included supervision with eating and self-care; and needing assistance with ambulation, bathing, , toileting, and transferring. Review of Resident #11's care plan showed that he was to receive toileting assistance (empty bag, clean all soiled areas) - 4 times daily at 7:00 a.m., 12:00 p.m., 4:00 p.m., and 9:45 p.m. He required mobility assistance (assisting to and from) 1 time on Monday, Wednesday, and Friday, at 7:00 a.m. Review of Resident #11's medication administration record (MAR) for , had care for emptying ostomy bag four times daily scheduled at 7:00 a.m., 2:00 p.m., 5:00 p.m., and 9:00 p.m. There was a total of 5 exceptions documented for the care not being provided on at 5:00 p.m., at 7:00 a.m., at 7:00 a.m., at 7:00 a.m., and at 2:00 p.m. 2. Review of Resident #3's health record showed that she was admitted to the facility on . Her Form 1823 dated showed that she had diagnoses of , , , , hypertensive , , and . Her ADL needs included needing assistance with ambulation, bathing, , self-care, toileting, and transferring; she was independent with eating. Review of Resident #3's call button response log showed that the resident pushed her call button 1 time on at 8:01 p.m., and it was not responded to for 144 minutes. On at 4:13	A 025		

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A 025	Continued From page 3 p.m., she pushed her call button 2 times, and it was not responded to for 58 minutes. On at 7:28 p.m., she pushed her call button 5 times, and it was not responded to for 59 minutes. On at 7:15 a.m., she pushed her call button 6 times, and it was not responded to for 71 minutes. 3. During an interview on at 10:22 a.m., the Regional Director of Wellness said that the facility couldn't provide the scheduled ostomy care if the resident is not in house. She said that she remembered Resident #11 went out a lot and suggested that maybe he got picked up early to go to . She said that the call button response procedure is that when the resident pushed their call button, it would go to a pager. The page would be received on computers in the office, and the front desk; and she said that sometimes they don't always clear. She said she was not sure if they had a policy on call lights. Class III .	A 025		
A 030 SS=D	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.	A 030		

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A 030	Continued From page 4	A 030		

(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 , ;
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;

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A 030	Continued From page 5 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 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,	A 030		

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A 030	Continued From page 6	A 030		

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.
(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

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A 030	Continued From page 7 , , , 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 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	A 030		

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A 030	Continued From page 8	A 030		

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 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

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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 in consideration of personal dignity, and they failed to provide adequate and appropriate health care in the management of medications and the provision of health care services for 1 (Resident #11) of 3 residents reviewed. The lack of, or poor quality services can lead to poor health outcomes and negative effects on equality of opportunity and dignity.

The findings included:

1. Review of Resident #11's record showed that he was admitted to the facility on . His Health Assessment (Form 1823) showed that he had a diagnosis of and required three times weekly on Monday, Wednesday, and Friday. His activities of daily living (ADL) needs included supervision with eating and self-care; and needing assistance with ambulation, bathing, toileting, and transferring.

Review of Resident #11's care plan showed that he was to receive toileting assistance (empty bag, clean all soiled areas) - four times daily at 7:00 a.m., 12:00 p.m., 4:00 p.m., and 9:45 p.m. He required mobility assistance (assisting to and

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A 030	Continued From page 10 from ,) 1 time on Monday, Wednesday, and Friday, at 7:00 a.m. Review of Resident #11's medication administration record (MAR) for , had care for emptying ostomy bag four times daily scheduled at 7:00 a.m., 2:00 p.m., 5:00 p.m., and 9:00 p.m. There was a total of five exceptions documented for the care not being provided on at 5:00 p.m., at 7:00 a.m., at 7:00 a.m., at 7:00 a.m., and at 2:00 p.m. 2. Review of Resident #11's MAR for showed that he did not receive his , chewable 81 milligram (mg) tablet (used as a), instructed to take one tablet by once daily and scheduled for 8:00 a.m., was not given on at 8: 00 a.m., and marked as an exception due to resident not in community. His , 2.5 mg tablet ( ), instructed to take one tablet by twice daily, and scheduled for 8:00 a.m., and 8:00 p.m., was not given on at 8:00 a.m. and marked as an exception due to resident not in the community. His (,) 10 mg tablet (treats rapid changes in , when changing positions), instructed to take one tablet by three times daily, and scheduled for 6:00 a.m., 2:00 p.m., and 10:00 p.m., was not given on at 6:00 a.m. and marked as an exception for resident not in the community. His sevelamer 800 mg tablet (, , binder for ,), instructed to take two tablets by three	A 030		

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A 030	Continued From page 11 times daily, and scheduled for 8:30 a.m., 5:00 p.m., and 8:00 p.m., was not given on at 8:30 a.m. and marked as an exception for resident not in the community. This medication was not given for "resident not in the community" 2 of 90 times in . Review of Resident #11's MAR for , showed that he did not receive his , Chewable 81 milligram (mg) tablet, instructed to take one tablet by once daily, scheduled at 8:00 a.m. on , , , and and was marked as an exception due to resident not in the community. His , Oral 2.5 mg tablet, instructed to take one tablet by twice daily, scheduled at 8:00 a.m. and 8:00 p.m., was not given at 8:00 a.m. on , , , , and due to resident not in the community. His gas relief 125 mg softgel, instructed to take one capsule by three times a day and scheduled for 8:00 a.m., 12:00 p.m., and 5:00 p.m., was not given and marked as an exception for resident not in the community on at 12:00 p.m., and on at 12:00 p.m. His 10 mg tablet, instructed to take one tablet by three times daily and scheduled for 6:00 a.m., 2:00 p.m., and 10:00 p.m. was not given on at 6:00 a.m., at 6:00 a.m., at 6:00 a.m., and at 2:00 p.m. and were marked as exceptions due to resident not in the community. This prescription ran from to 4?26 at 6:00 a.m. His (,) 10 mg tablet, instructed to take one tablet by three times a day, scheduled for 8:00 a.m., 12:00 p.m., and	A 030		

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A 030	Continued From page 12 5:00 p.m., was not given on at 12:00 p.m., and at 12:00 p.m., and it was marked as an exception for resident not in the community. This prescription ran from at 5:00 p.m. to at 5:00 p.m. This medication was not given for "resident not in the community" 6 of 90 times in , . His sevelamer 800 mg tablet, instructed to take one tablet by three times a day with meals/snack on Monday, Wednesday, and Friday, and scheduled for 8:00 a.m., 12:00 p.m., and 5:00 p.m., was not given on at 12:00 p.m. and marked as an exception due to resident not in the community. This prescription was utilized from to . His sevelamer 800 mg tablet, instructed to take two tablets by three times a day with meals on Sunday, Tuesday, Thursday, and Saturday, and scheduled for 8:00 a.m., 12:00 p.m., and 5:00 p.m., was not given on at 12:00 p.m. and marked as an exception due to resident not in the community. This prescription was utilized from to . His sevelamer 800 mg tablet, instructed to take two tablets by three times daily, scheduled at 8:30 a.m., 5:00 p.m., and 8:00 p.m., was not given at 8:30 a.m. on , , , and and marked as an exception due to resident not in the community. This prescription was utilized on , , , , , , , , , and . His sevelamer 800 mg tablet, instructed to take two tablets by three times daily, and scheduled for 8:00 a.m., 12:00 p.m., and 5:00 p.m., was not given on at 12:00 p.m. and marked as an exception for	A 030		

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ANGELS SENIOR LIVING AT SARASOTA	5750 HONORE AVENUE SARASOTA, FL 34233

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A 030	Continued From page 13	A 030		

resident not in the community. This prescription was utilized on , , , , , , , , , , , , and . This medication was not given for "resident not in the community" 7 of 90 times in .

During an interview on at 10:22 a.m., the Regional Director of Wellness said that the facility couldn't provide the scheduled ostomy care if the resident is not in house and as far as medications (meds), it really depends - if they are not in the building, then they would not be given those meds, because we have one hour before and one hour after. If they leave at 6:00 a.m. and the meds are scheduled at 7:00 a.m., then they could give them the meds before the person leaves. They could pack their meds if the resident asks to pack the meds. Typically, we would prompt the resident and ask how long they would be gone. We would ask them if they need the med packed. If they are in memory care, then we would need probably a private caregiver. The option would be to give it before, or to give it to them to pack with them for an AL resident.

During an interview on at 10:40 a.m., the Regional Director of Sales and former Administrator of the facility said Resident #11 would go to three days a week. Providing the actual ostomy care was home health. Our staff would just empty the bags. Home health would come in more than we could bill for. Every so many hours they would have to be emptied, and we would have to burp them also - four times a day, but it was actually more often than that. Staff would bring him to . We would probably have not scheduled for him to have meds during . We would ask for a time that he was in the community; the Wellness

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A 030	Continued From page 14 Coordinator would have been responsible for providing that. The ED (Executive Director) is ultimately responsible for everything, so I would have to look at his MAR, but unless a doctor specifically asked for medication to be given at that time, then we would ask to change it - otherwise he would miss his meds 3 time a week. Class III .	A 030		
A 032 SS=E	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),	A 032		

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A 032	Continued From page 15 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 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 ensure residents deemed an elopement risk have identification on	A 032		

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A 032	Continued From page 16	A 032		

their persons to include their name, the facility's name, address, and telephone number for 9 (Resident #13, #15, #16, #17, #18, #21, #22, #23 and #24) of 10 residents deemed an elopement risk. Failure to ensure identification is on each at risk resident, if an elopement occurs, the first responders are able to notify and return the resident to the correct facility timely.

The findings included:

On at 9:30 a.m., Requested and received from the Administrator a list of residents deemed as an elopement risk currently in the facility, which indicated the facility had 10 residents listed as an elopement risk.

1. Review of Resident #13's record revealed a Resident Health Assessment Form 1823 dated , indicating Resident #13 was an elopement risk with a diagnosis of , , , , , and Covid with behavioral status and elopement special precautions.

On at 9:52 a.m., during a tour of the Memory Care Unit, Resident #13 was observed to not be wearing any identification on his person.

2. Review of Resident #15's record revealed a Resident Health Assessment Form 1823 dated , indicating Resident #15 was an elopement risk with a diagnosis of Type II , history of right replacement, history of skin , and with behavioral status.

On at 9:52 a.m., during a tour of the Memory Care Unit, Resident #15 was observed

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A 032	Continued From page 17 to not be wearing any identification on his person. 3. Review of Resident #16's record revealed a Resident Health Assessment Form 1823 dated , indicating Resident #16 was an elopement risk with a diagnosis of , , , , and a left , , with behavioral status with constant redirection. On at 9:52 a.m., during a tour of the Memory Care Unit, Resident #16 was observed to not be wearing any identification on his person. 4. Review of Resident #17's record revealed a Resident Health Assessment Form 1823 dated , indicating Resident #17 was an elopement risk with a diagnosis of , , , , , , , and , . On at 9:55 a.m., during a tour of the Memory Care Unit, Resident #17 was observed to be without any identification on his person. 5. Review of Resident #18's record revealed a Resident Health Assessment Form 1823 dated , indicating Resident #18 was an elopement risk with a diagnosis of , , , , , Barrett , , current , frequent resulting in injury, , and elevated , and decline. On at 9:55 a.m., during a tour of the Memory Care Unit, Resident #18 was observed	A 032		

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A 032	Continued From page 18 to be without any identification on his person. 6. Review of Resident #21's record revealed a Resident Health Assessment Form 1823 dated , indicating Resident #21 was an elopement risk with a diagnosis of with a status of needs direction and prompting. On at 9:55 a.m., during a tour of the Memory Care Unit, Resident #21 was observed to be without any identification on her person. 7. Review of Resident #22's record revealed a Resident Health Assessment Form 1823 dated , indicating Resident #22 was an elopement risk with a diagnosis of unspecified and a behavioral status of unspecified . On at 9:55 a.m., during a tour of the Memory Care Unit, Resident #22 was observed to be without any identification on her person. 8. Review of Resident #23's record revealed a Resident Health Assessment Form 1823 dated , indicating Resident #23 was an elopement risk with a diagnosis of , dyslipidemia, and recent complicated with a behavioral status of advanced . On at 10:00 a.m., during a tour of the Memory Care Unit, Resident #23 was observed to be without any identification on her person. 9. Review of Resident #24's record revealed a	A 032		

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A 032	Continued From page 19 Resident Health Assessment Form 1823 dated , indicating Resident #24 was an elopement risk with a diagnosis of , , , , and Memory , . On at 10:00 a.m., during a tour of the Memory Care Unit, Resident #24 was observed to be without any identification on her person. On at 8:20 a.m., during a tour of the Memory Care Unit, Resident #13, #15, #16, #17, #18, #21, #22, #23 and #24 were observed to be without identification on their person. On at 8:35 a.m., during an interview, the Memory Care Director said that the residents take the off and should have them on. She acknowledged that the Elopement Risk Residents did not have identification on their persons. The Memory Care Director then went to the nurse's station and began creating new for the residents. On at 12:35 p.m., during an interview, the Administrator, the Regional Director of Wellness, and the Regional Director of Sales acknowledged the fact that there weren't identification on 9 out of 10 Elopement Risk Residents. The Regional Director of Wellness stated, "It was a shame that no one had the identification on." Class III .	A 032		
A 052 SS=E	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin	A 052		

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

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A 052	Continued From page 21 the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a , of the body. (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH	A 052		

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A 052	Continued From page 22 SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , _ or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving	A 052		

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A 052	Continued From page 23	A 052		

the facility, with this fact noted in the resident's medication record,
3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or
4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging.
(f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S.
(g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition.
(h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication.

This Statute or Rule is not met as evidenced by:
Based on observation, and interview, the facility failed to ensure staff who assist residents with self-administration of medications do so in accordance with proper procedure for 4 (Residents #17, #18, #19, #20) of 6 medications observations.

The findings included:

1. On at 7:50 a.m., Med Tech Staff C was observed assisting Resident #18 with the following medications: , 5mg (,), , 50 mg ( ), , 40 mg ( ), , 25mg ( ). Staff C

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went to the med cart parked down the dining room in the memory care unit and removed Resident #18's medication from the cart. Staff C placed the dose of each medication into a cup and walked the cup to Resident #18 sitting in the dining room. Staff C placed the cup on the table in front of the resident, and said, "here you go." Staff C did not inform Resident #18 what medications and dosages he was being given; Staff C did not perform hygiene before and after assisting Resident #18 with medications. Staff C continued to the next resident.

2. On at 7:56 a.m., Med Tech Staff C was observed assisting Resident #19 with the following medications: , 81mg ( ), ( ), 325mg ( ), 25mg ( ), 50 mcg (,), .4 mg (,). Staff C went to the med cart parked in the dining room in the memory care unit and removed Resident #19's medication from the cart. Staff C placed the dose of each medication into a cup and walked the cup to Resident #19 sitting in the dining room. Staff C placed the cup on the table in front of the resident, and said, "here you go." Staff C did not inform Resident #19 what medications and dosages he was being given; Staff C did not perform hygiene before and after assisting Resident #19 with medications. Staff C continued to the next resident.

3. On at 8:01 a.m., during an interview, Resident #20 stated, "Are you writing about the medications cause last night they did not give me my meds, I did not get any meds, and the girls said they did not have them to give me.

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A 052	Continued From page 25 On at 8:03 a.m., Med Tech Staff C was observed assisting Resident #20 with the following medications: 0.25 mg ( ), 5 mg ( ), 100 mg ( ), 25-100 mg ('s). Staff C went to the med cart parked in the dining room in the memory care unit and removed Resident #20's medication from the cart. Staff C placed the dose of each medication into a cup and walked the cup to Resident #20 sitting in the dining room. Staff C placed the cup on the table in front of the resident, and said, "here is your medicine." Staff C did not inform Resident #20 what medications and dosages she was being given; Staff C did not perform hygiene before and after assisting Resident #20 with medications. Staff C continued to the next resident. 4. On at 8:07 a.m., Med Tech Staff C was observed assisting Resident #17 with the following medications: 5mg ( ) 81mg ( ), 20 mg ( ), 10mg ( ), 10 mg ( ), Refresh tears (dry), 500/Salmeterol 500mg ( ), Trelegy 62.5mcg/25mcg ( ) 200 mg ( ). Staff C went to the med cart parked in the dining room in the memory care unit and removed Resident #17's medication from the cart. Staff C placed the dose of each medication into a cup and walked the cup to Resident #17 walking in the dining room, and had him sit on a chair in the hallway. Staff C placed the cup on the table next to the resident, and said, "this is for you." Staff C did not inform Resident #17 what medications and dosages he was being given; Staff C did not perform	A 052		

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A 052	Continued From page 26 hygiene before and after assisting Resident #17 with medications. Staff C continued to the next resident. On at 8:16 a.m., during an interview, Med Tech Staff C said she only tells the residents what meds they are being given if they ask. Staff C stated, "If they don't ask, I do not tell them, only if they ask." On at 8:38 a.m., during an interview, the Administrator said all staff assisting with meds are med techs, and they are to follow the policies and procedures they learn in med class that includes proper hygiene. The Administrator said hygiene is washing after each med pass or use of sanitizer between each med pass and the med techs should be telling the residents what meds and dosages being given, On at 9:16 a.m., during an interview, the Administrator and the Memory Care Director confirmed Med Tech Staff C did not follow the proper procedure when assisting the residents with their medications. Class III .	A 052		
A 056 SS=E	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized	A 056		

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A 056	Continued From page 27 patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record.	A 056		

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A 056	Continued From page 28 (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record	A 056		

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A 056	Continued From page 29	A 056		

review, the facility failed to provide medications as ordered by the physician and ensure that prescriptions are ordered and or reordered in a timely manner and available for 5 (Resident #11, #14, #17, #19, #20) of 6 residents reviewed.

The findings included:

Review of the policy titled: Medication Information (no effective date) included, "Angels Senior Living will order the medications form the pharmacy, contact doctors for refills, and do all we can to assure that residents have their medications refilled in a timely manner. . . . Medications are ordered in a timely fashion and need to be supplied in a timely fashion."

1.On at 12:00 p.m., observation of the Memory Care Director (MCD) assisting Resident #17 with medications revealed the MCD looked into the med cart parked in the dining room for Resident #17's 200 mg capsule. The medication was not available in the medication cart to be given.

On at 8:07 a.m., Med Tech Staff C was observed assisting Resident #17 with the following medications: 5mg ( ), 81mg ( ), 20 mg ( ), 10mg ( ), 10 mg( ), Refresh tears (dry), 500/Salmeterol 500mg, Trelegy 62.5mcg/25mcg (/) 200 mg. 200 mg, , 2.5 mcg medications were not available in the med cart to be given.

On at 8:13 a.m., during an interview, Med Tech Staff C confirmed Resident #17's

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A 056	Continued From page 30 medication is not available to give and she marked them "not available." On at 9:00 a.m., during a review of the med cart with the Administrator and the MCD for Resident #17's medications revealed as confirmed by the Administrator and the MCD; Resident #17 did not have the and , medication to be given. Review of the Electronic Medication Administration Record (EMAR) for Resident #17 for the Month of , failed to show Resident #17 received the following medications: 200 mg 12:00 p.m., 5:00 p.m., 8:00 a.m., documented "medication not available, waiting on pharmacy." , , 2.5 mcg 8:00 a.m. not available in med cart. , 20 mg 7:00 a.m. med not available in med cart. On at 9:22 a.m., during an interview, the Regional Wellness Director (RWD) said it is unacceptable for Resident #17 to have been waiting on medication that was reordered since . The RWD said the MCD is responsible to make sure medications are delivered on time and follow up to make sure the meds are onsite at the facility. The RWD confirmed the MCD is not following procedure to make sure meds are delivered timely for residents so med techs can have them onsite to be given. On at 9:10 a.m., during an interview, the Administrator confirmed the medications were not onsite to give the residents as ordered by the physician. 2. On at 7:56 a.m., Med Tech Staff C was	A 056		

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A 056	Continued From page 31 observed assisting Resident #19 with the following medications: , 81mg ( ), , , 325mg ( ), , 25mg ( ), 50 mcg, 0.4 mg (,), 1000 mcg, D 2000 mg, 5 mg, , 2.5 mg. Staff C went to the med cart parked in the dining room in the memory care unit and removed Resident #19's medication from the cart. B-1 100 mg was not available in the cart to be given On at 7:59 a.m., during an interview, Med Tech Staff C said sometimes they have residents out of meds, and they just write "not available." Review of the Electronic Medication Administration Record (EMAR) for Resident #19 for the Month of failed to show Resident #19 received the following medications: B-1 100 mg 8:00 a.m. not available in med cart. Review of the Month of revealed: 10 mg 8:00 pm med not available. 3. On at 8:01 a.m., during an interview, Resident #20 stated, "Are you writing about the medications; cause last night they did not give me my meds. I did not get any meds, and the girls said they did not have them to give me." On at 8:03 a.m., Med Tech Staff C was observed assisting Resident #20 with the following medications: , 0.25 mg ( ), , 5 mg ( ), 100 mg ( ), 25-100 mg ('s), 1 gm, , 50 mg,	A 056		

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A 056	Continued From page 32 0.25 mg. 1 gm, 50 mg, 0.25 mg medications were not available on the med cart to be given. Review of the Electronic Medication Administration Record (EMAR) for Resident #20 for the Month of failed to show Resident #20 received the following medications: Hipp 1 gm on 5:00 p.m., and 8:00 a.m. as not available in the med cart, 50 mg on 8:00 a.m. as not available in the med cart, 0.25 mg 5:00 p.m., 8:00 am not available in the med cart. Review of the Month of revealed: 0.25 mg 2:00 p.m. out of med. 8:00 a.m., 2:00 p.m. awaiting med. 2:00 p.m. awaiting delivery. 8:00 a.m., 8:00 p.m. waiting for doctor to refill. 8:00 p.m. waiting for pharmacy. 2:00 p.m. awaiting delivery. - 25-100 mg 5:00 p.m. Med not available. 4. Review of the Electronic Medication Administration Record (EMAR) for Resident #18 for the Month of failed to show Resident #18 received the following medications: 20 mg on 8:00 a.m. Med not available, 5 mg on 8:00 p.m. Med not available. 5. Review of Resident #11's medication administration record (MAR) for showed his ( ) 10 mg (milligram) tablet, instructed to take one tablet by three times daily, and scheduled for 6:00	A 056		

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A 056	Continued From page 33	A 056		

a.m., 2:00 p.m., and 10:00 p.m., was not given on at 2:00 p.m. and 10:00 p.m., on at 6:00 a.m. and 2:00 p.m. and marked as an exception due to medication not available - on order from pharmacy.

His , chewable 81 mg tablet, instructed to take one tablet by once daily, and scheduled for 8:00 a.m., was not given on and marked as an exception due to medication not available - on order from pharmacy.

His 4 gm (gram) oral packet, instructed to mix one packet with water and drink once daily at bedtime, and scheduled for 8:00 p.m., was not given on , , and and marked as an exception due to medication not available - on order from pharmacy.

Review of Resident #11's MAR for showed his , 2.5 mg tablet, instructed to take one tablet by twice daily, and scheduled for 8:00 a.m. and 8:00 p.m., was not given on at 8:00 a.m. and marked as an exception due to medication not available -on order from pharmacy.
His , 5 mg tablet, instructed to take ½ tablet by 2 times a day, and scheduled for 8:00 a.m. and 8:00 p.m., was not given at 8:00 a.m. on , , and and marked as an exception due to medication not available - on order from pharmacy.

His sevelamer 800 mg tablet, instructed to take two tablets by three times daily, and scheduled for 8:00 a.m., 12:00 p.m., and 5:00 p.m., was not given on at 12:00 p.m., and 5:00 p.m. and marked as an

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A 056	Continued From page 34 exception due to medication not available - on order from pharmacy. Class III	A 056		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable	A 078		

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A 078	Continued From page 35 (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure within 30 days of employment staff submit a written statement from a health care provider documenting the individual is free from signs/symptoms of communicable , ( ) for 2 (Staff C,	A 078		

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A 078	Continued From page 36 Memory Care Director) of 4 employee records reviewed. The findings included: Review of Staff C's file revealed a hire date of as a Caregiver/med tech. Staff C's file contained evidence of documentation of a test and written statement completed on . The statement from the healthcare provider indicating Staff C was free from signs/symptoms of communicable was not completed within 30 days of hire. Review of the Memory Care Director's (MCD) file revealed a hire date of . The MCD's file contained evidence of documentation of a test and written statement completed on . The statement from the healthcare provider indicating staff C was free from signs/symptoms of communicable was not completed within 30 days of hire. On at 12:15 p.m.., The Administrator confirmed the statements were not completed within the required time frame for Staff C and the Memory Care Director. Class III .	A 078		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training	A 081		

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A 081	Continued From page 37	A 081		

must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee ' s personnel record.
(b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d).
(c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a).

(7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course.

59A-36.011
(2) STAFF PRESERVICE ORIENTATION.
(a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted

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A 081	Continued From page 38 living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents.	A 081		

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A 081	Continued From page 39 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures.	A 081		

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A 081	Continued From page 40	A 081		

This Statute or Rule is not met as evidenced by:
Based on record review, and interview, the facility failed to ensure staff complete required training based on the Facility's policy and procedures (Pre-service Orientation, , Neglect and , , control, Universal Precautions and Sanitation, Emergency Procedures, and Elopement) within 30 days of hire for 3 (Staff C, Memory Care Director and the Administrator) of 4 records reviewed.

The findings included:

1. Record review for Staff C revealed a hire date of as a caregiver/medication technician. Further review revealed documentation of certificates of completion for 2 hours of Pre-service orientation on , 1 hour of , Neglect and , on , 1 hour of Control and Universal Precautions on , 1 hour of Major Emergency Preparedness and Evacuation on , and Elopement and completed on , were from an on-line training course rather than from the Facility's policy and procedures.

2. Record review for the Administrator revealed a hire date of . Further review revealed documentation of certificates of completion for 2 hours of Pre-service orientation on , 1 hour of , Neglect and , on , 1 hour of Control and Universal Precautions on , 1 hour of Major Emergency Preparedness and Evacuation on

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A 081	Continued From page 41 , and Elopement and completed on , were from an on-line training course rather than from the Facility's policy and procedures. 3. Record review for the Memory Care Director (MCD) revealed a hire date of . Further review revealed documentation of certificates of completion for 1 hour of , Neglect and , on , and Elopement and completed on ,were from an on-line training course rather than from the Facility's policy and procedures. On at 12:00 p.m., during an interview, the Administrator said she is the person responsible for the employee records and sets up the employees for training, and they use online computer training through MyAlftraining.com. The Administrator confirmed the training is not based on the Facility's policies and procedures. Class III .	A 081		
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	A 090		

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A 090	Continued From page 42 regarding within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure facility employees complete at least one hour of training in ( ) within 30 days after employment based on the Facility's policies and procedures for 3 (Staff C, Memory Care Director, Administrator) of 4 employee files reviewed. The findings included: Review of Staff C's employee file revealed a hire date of as a Caregiver/med Tech. Staff C's file contained evidence of documentation of a certificate of completion for 1 hour of - training completed on were from an on-line training course rather than from the Facility's policy and procedures. Review of the Memory Care Director's (MCD) file revealed a hire date of . The MCD's file contained evidence of documentation of a certificate of completion for 1 hour of - training completed on were from an on-line training course rather than from the Facility's policy and procedures. Review of the Administrator's file revealed a hire date of . file contained evidence of documentation of a certificate of completion for 1 hour of - training completed on were from an on-line training course rather than from the Facility's	A 090		

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A 090	Continued From page 43 policy and procedures. During an interview on [redacted] at 12:00 p.m., the Administrator confirmed trainings completed were not based on the Facility's policy and procedures. Class III .	A 090		

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ZZ830 SS=D	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider	ZZ830		

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ZZ830	Continued From page 1	ZZ830		

is located in a geographic area in which a state of emergency was declared by the Governor if the provider:
1. Suffered damage to its operation during the state of emergency.
2. Is currently licensed.
3. Does not have a provisional license.
4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months.
(b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes.

(4) . . . Licensees providing residential or inpatient services must utilize an online database

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ZZ830	Continued From page 2	ZZ830		

approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations.

This Statute or Rule is not met as evidenced by:
Based on record review, and interview, the facility failed to submit annually and within the required time frame for requested changes, and maintain documentation of a current Comprehensive Emergency Management Plan (CEMP), approved by the local emergency management agency to ensure the safety and welfare of all residents.

The findings included:

Review of the facility Comprehensive Emergency Management Plan (CEMP) revealed an approval letter dated . The letter indicated that the facility's CEMP was approved for 12 months from the date of the approval letter.

On at 9:50 a.m., during an interview, the Regional Director of Sales (RDS) said the facility did not receive an approval letter for the CEMP for 2024, there were challenges with the previous administrator last year, and one of the regional directors became the interim Administrator and was taking care of submission of the CEMP/EPP for approval. The RDS confirmed the facility currently does not have an approved CEMP.

On at 9:55 a.m., during an interview, the Administrator said she has not submitted the facility CEMP as yet. The Administrator confirmed the facility currently does not have an approved CEMP.

On at 10:45 a.m., during an interview, the Regional Director said the previous Administrator

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ZZ830	Continued From page 3 at the time submitted the CEMP/EPP on and it was rejected on . The RD said the previous Administrator was terminated in the end of , and when he was going through the facility files he saw the rejection letter for the CEMP. The RD said the previous Administrator never resubmitted the required documentation requested for the CEMP and the information never came to him. He said he redid the CEMP for the crosswalk and he resubmitted the facility CEMP in . The RD states currently the facility has not had an approved CEMP since 2023. Class III	ZZ830		