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
	AL11966500	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLORY ASSISTED LIVING FACILITY	7221 UDINE AVENUE ORLANDO, FL 32819

(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 investigation (2025006209) and a generator monitoring survey were conducted at Glory Assisted Living Facility on . The facility had deficiencies at the time of the survey. A Class 1 deficiency was found at Tag A0076 A class 1 deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance, has caused, or is likely to cause, serious injury, harm, , , or to a resident receiving care in a facility. The facility failed to notify hospice before calling 911, failed to provide the ( ) to first responders, (which resulted in life saving measures being performed) on 1 of 1 sampled resident (#6), and failed to have one consistent policy. The class 1 noncompliance began on .	A 000		
A 076 SS=J	59A-36.009 FAC ( ) (1) POLICIES AND PROCEDURES. (a) Each assisted living facility must have written policies and procedures that explain its implementation of state laws and rules relative to ( ). An assisted living facility may not require execution of a as a condition of admission or treatment. The assisted living facility must provide the following to each resident, or resident's representative, at the time of admission:	A 076		

AHCA Form 3020-0001

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

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A 076	Continued From page 1 1. Form SCHS- , "Health Care Advance Directives - The Patient's Right to Decide," , , or with a copy of some other substantially similar document, which incorporates information regarding advance directives included in chapter 765, F.S. Form SCHS- is available from the Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 34, Tallahassee, FL 32308 or the agency's website at: http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/HC_Advance_Directives/docs/adv_dir.pdf; and, 2. DH Form 1896, Florida Form, , 2004, which is hereby incorporated by reference. This form may be obtained by calling the Department of Health's toll free number 1(800)226-1911, extension 2780 or online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04005. (b) There must be documentation in the resident's record indicating whether a DH Form 1896 has been executed. If a DH Form 1896 has been executed, a yellow copy of that document must be made a part of the resident's record. If the assisted living facility does not receive a copy of a resident's executed DH Form 1896, the assisted living facility must document in the resident's record that it has requested a copy. (c) The executed DH Form 1896 must be readily available to medical staff in the event of an emergency. (2) LICENSE REVOCATION. An assisted living facility's license is subject to revocation pursuant to section 408.815, F.S., if, as a condition of treatment or admission, the facility requires an individual to execute or waive DH Form 1896. (3) PROCEDURES. Pursuant to section 429.255, F.S., an assisted living facility must	A 076		

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A 076	Continued From page 2 honor a properly executed DH Form 1896 as follows: (a) In the event a resident experiences or , staff trained in ( ) or a health care provider present in the facility, may withhold , (, , and). (b) In the event a resident is receiving hospice services and experiences or , , facility staff must immediately contact hospice staff. The hospice procedures take precedence over those of the assisted living facility. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to notify hospice before calling 911, failed to provide the ( ) to first responders, (which resulted in life saving measures being performed) on 1 of 1 sampled resident (#6), and failed to have one consistent policy. Findings: Review of the medical record revealed resident #6 was admitted to the facility on . On the resident was admitted to hospice services for and . Review of resident #6's chart revealed a completed , dated . The chart also had a blank , dated , that indicated "patient refuses ." A chart review revealed a policy, signed by	A 076		

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A 076	Continued From page 3 resident #6 on . The policy indicated the facility would honor a . The policy read, in the event a resident is receiving hospice services and experiences , , , the facility staff must immediately contact hospice. The hospice procedures shall take precedence over those of the assisted living facility. The chart review also revealed a policy, dated , which indicated the facility would call 911 for all residents who were found to need emergency medical care. Facility staff would initiate , , ( ) and continue until emergency response personnel arrived. Emergency response personnel would be presented with the , and they would make the decision whether or not the should be honored. Neither policy indicated where a resident's would be maintained within the facility. On at 10:59 AM, Caregiver B said that on at around 6:30 AM resident #6 was in her bed. Her breathing sounded rattled. The Caregiver called the facility's owner to inform her. Caregiver B then called 911. The Caregiver said she did not know if the resident had a . On between 10:59 AM-11:30 AM, interviews with Caregivers A, B, and C revealed none of the Caregivers knew where to find the . On at 12:30 PM, the Administrator said the facility owner called her after hearing from Caregiver B. The Administrator then called hospice and told them 911 was called for the resident. When questioned why 911 was called before calling hospice, the Administrator said she	A 076		

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A 076	Continued From page 4 told the hospice representative who answered the phone what condition the resident was in, and the representative replied, "you can call 911." The Administrator said she never asked the hospice about a for resident #6. She said no one from the hospice told her a was placed in the resident's chart. She said the facility's policy was to honor a . If on hospice, they were to be called first and their procedures took precedence. She said a resident's should be hung on the resident's room door and a copy placed in their chart. At the time of the survey, nothing was put in place to prevent this from happening again. On at 3:35 PM The hospice nurse stated she brought the hospice admission packet to the facility on . She stated she reviewed the packet with the Administrator including the existence of the . Review of an incident report dated , indicated on , at approximately 6:20 AM, the resident woke up and exhibited abnormal breathing patterns. 911 was called. The first responders took resident#6 out of her room to the hall and began . , . The first responders were not given the . Resuscitative measures were unsuccessful, and the resident was left at the facility. The resident was then left on the floor in front of the hallway. Time of was recorded as 6:59 AM. On at 3:19 PM, the hospice social worker said she arrived at the facility on at approximately 8:45 AM, to find resident #6 lying on the floor, inside the foyer. The social worker said she asked if the resident could be placed in her bed. The facility owner agreed but the	A 076		

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A 076	Continued From page 5 Administrator said no, they would leave the resident there until the funeral home picked her up. The social worker stated she questioned why 911 was called and the Administrator told her the resident had been a full code since her admission to the facility. The social worker stated she showed the owner a picture of the on her phone, and confirmed she and the owner found the paper in the resident's chart. The social worker said the owner and the Administrator were surprised to learn there was a . On at 1:04 PM, the facility owner confirmed on the day of the incident, the hospice social worker first showed her a copy of the resident's on her phone and both the owner and the social worker looked in the resident #6's chart and found there was a valid . Review of the fire rescue report revealed rescue arrived at the facility on at 6:29 AM. They carried the resident from her bed to the living room floor because her room was too cluttered. As part of their resuscitative measures they performed manual , , administered , at 25 liters per minute, performed oral suctioning due to a significant amount of and , obtained intraosseous access in her left , administered four rounds of , , and inserted an tube. Resuscitative measures were stopped at 6:56 AM. (Intraosseous access involves inserting a specialized needle into the medullary , of bone to deliver fluids, medications, or obtain laboratory samples, serving as a rapid and reliable alternative when access is delayed or unfeasible. https://www.ncbi.nlm.nih.gov/books/NBK554373/)	A 076		

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A 076	Continued From page 6 Review of an incident report revealed resident #6's body was left in the hall for approximately 7 hours. The funeral home did not arrive to remove the remains until 1:35 PM. This prolonged exposure caused significant and distress to other residents present in the facility during that time. A brightly colored purple hospice paper in the resident's chart instructed the facility to call hospice immediately for any change in the resident's condition. In the resident's chart there were hospice plan of care reviews, dated , , , , , and . All of them indicated the resident was a ( ). Class I	A 076		
A 077 SS=G	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the	A 077		

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A 077	Continued From page 7	A 077		

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.;
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

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A 077	Continued From page 8 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 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	A 077		

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A 077	Continued From page 9 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's administrator failed to ensure the operation and maintenance of the facility, including management and education of all staff and the provision of appropriate care to all residents was facilitated and maintained. Findings: Review of resident #6's record revealed a facility admission date of . On the resident was admitted to hospice services for and . Review of the record revealed a ( ), signed by a health care provider on .	A 077		

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A 077	Continued From page 10 The chart also had a blank , dated , that indicated "patient refuses ( )." A facility incident report dated , indicated that on at around 6:20 AM the resident woke up and exhibited abnormal breathing patterns. 911 was called. The Caregiver said she did not know if the resident had a . On at 10:59 AM, caregiver B said that on at around 6:30 AM resident #6 was in her bed. Her breathing sounded rattled. The Caregiver called the facility's owner to inform her. The caregiver then called 911. On at 11:26 AM, Caregiver A said she thought she received training on the facility's policy, but maybe not. She stated a meant you're not supposed to bring them . She stated she is unsure what is in the policy. She thinks the are in a cabinet above where the medication cart is stored. On at 11:30 AM, Caregiver C said a meant no , no ( ). She was trained on the policy but did not remember what it said. She said a is kept in the medication book. On at 11:36 AM, the facility owner confirmed caregiver B called her first that morning. The owner said when she arrived at the facility that morning, she looked in the resident's chart and saw only a blank . On at 12:30 PM, the Administrator said the facility owner called her after hearing from	A 077		

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A 077	Continued From page 11 Caregiver B. The Administrator then called hospice and told them 911 was called for the resident. When questioned why 911 was called before calling hospice, the administrator then said she told the hospice representative who answered the phone what condition the resident was in and the representative replied, "you can call 911." The Administrator said she never asked the hospice about a for resident #6. She said no one from the hospice told her a was placed in the resident's chart. She said the facility's policy was to honor a . If on hospice, they were to be called first and their procedures took precedence. She said a resident's should be hung on the resident's room door and a copy would be placed in their chart. On at 3:35 PM, hospice nurse E said that on she took the hospice admission packet to the facility at which time she went over the packet with the administrator and showed her the . Review of the fire rescue report revealed rescue arrived at the facility on at 6:29 AM. They carried the resident from her bed to the living room floor because her room was too cluttered. As part of their resuscitative measures they performed manual , , administered , at 25 LPM, performed oral suctioning due to a significant amount of and , obtained intraosseous access in her left , administered four rounds of , , , and inserted an tube. Resuscitative measures were stopped at 6:56 AM. (Intraosseous access involves inserting a specialized needle into the medullary , of bone to deliver fluids, medications, or obtain laboratory samples, serving as a rapid and	A 077		

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A 077	Continued From page 12 reliable alternative when access is delayed or unfeasible. https://www.ncbi.nlm.nih.gov/books/NBK554373/) A brightly colored purple hospice paper in the resident's chart instructed the facility to call hospice immediately for any change in the resident's condition. In the resident's chart there were hospice plan of care reviews, dated , , , , and . All of them indicated the resident was a . Caregiver A was hired on . A certificate of training indicated that the caregiver received 1-hour of training on the policies and procedures on . Caregiver B was hired on . A certificate of training indicated that the caregiver received 4-hours of training on adult , , and facility policy and procedure on . However, the training was received at a training center unrelated to the facility. There was no documentation to indicate the caregiver received training on this facility's policies. Caregiver C was hired on . A certificate of training indicated that the caregiver received 1-hour training on the policies and procedures on . On at 10:59 AM, caregiver B said she received training on the policy, which says if a resident is on hospice do not perform . If a resident has a , do not perform . She said a resident's is kept in their chart.	A 077		

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A 077	Continued From page 13 On at 11:26 AM, Caregiver A said she was not sure if she received training on the facility's policy. A meant you're not supposed to bring them . Regarding what the policy says, she thinks they told her, but she didn't write it down. She thinks the are in a cabinet above where the medication cart is stored. On at 11:30 AM, caregiver C said a meant no , no . She was trained on the policy but did not remember what it said. She said a is kept in the medication book. On at 12:30 PM, the administrator said the facility's policy was to honor a . If on hospice, they were to be called first and their procedures took precedence. She said a resident's was hung on the resident's room door and a copy was placed in their chart. On at 1:20 PM, the facility owner said caregiver B received the training at a training center and the facility's policies were not part of the training. On at 2:33 PM, the administrator said at the end of training she summarized what she went over. There was no process to determine the staff's comprehension of the training. Class II	A 077		
A 090 SS=D	59A-36.011(11) FAC Training - (11)	A 090		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 090	Continued From page 14 TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding . (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 2 of 3 sampled staff (A, C) comprehended the education they received on the facility's ( ) policies and failed to ensure 1 of 3 sampled staff (B) received training on the facility's policies. Findings: Review of personnel records revealed the following: Caregiver A was hired on . A certificate of training indicated that the caregiver received 1-hour of training on the policies and procedures on . Caregiver C was hired on . A certificate of training indicated that the caregiver received 1-hour training on the policies and procedures on . Caregiver B was hired on . A certificate	A 090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966500	A. BUILDING: _____ B. WING _____	06/18/2025

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A 090	Continued From page 15 of training dated , indicated the caregiver received 4-hours of training on adult , , , ( ), , and facility policy and procedure. However, the training was completed at a training center unrelated to the facility. There was no documentation to indicate the caregiver received training on this facility's policies. On at 10:59 AM, Caregiver B said she received training for the policy, which indicated if a resident is on hospice, do not perform . If a resident has a , do not perform . She said a resident's is kept in their chart. On at 11:26 AM, Caregiver A said she thought she received training on the facility's policy, but maybe not. She stated a meant you're not supposed to bring them . Caregiver A stated she believes the completed are in a cabinet above where the medication cart is stored. On at 11:30 AM, caregiver C said a meant no , no . She was trained on the policy but did not remember the contents of the policy. She said a is kept in the medication book. On at 12:30 PM, the Administrator said the facility's policy was to honor a . If on hospice, they were to be called first and their procedures took precedence. She said a resident's was hung on the resident's room door and a copy was placed in their chart. On at 1:20 PM, the facility owner confirmed that caregiver B received the training at a training center and the facility's	A 090		

Agency for Health Care Administration

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A 090	Continued From page 16 policies were not part of the training. On at 2:33 PM, the Administrator stated at the end of training she would summarize the education. The Administrator confirmed there was no process to determine the staff's comprehension of the training. Class III	A 090		