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
	AL11969790	A. BUILDING: _____ B. WING _____	07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HARRISON ASSISTED LIVING AND MEMORY CA	650 NW FORK RD STUART, FL 34994

(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 Abbreviated Relicensure with an Initial Limited Nursing Services (LNS) survey, Complaint surveys (#2024012033, #2024013059, #2024016777 & #2025006204), and a Generator Monitoring survey were conducted on at The Harrison Assisted Living And Memory Care Of Stuart. The facility had deficiencies related to the Relicensure and LNS surveys identified at the time of the visit.	A 000		
A 010	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices.	A 010		

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A 010	Continued From page 1 (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been	A 010		

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A 010	Continued From page 2 placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a , may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services	A 010		

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A 010	Continued From page 3 license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however,	A 010		

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A 010	Continued From page 4	A 010		

staff may not exceed the scope of their professional licensure or training.
(g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C.

This Statute or Rule is not met as evidenced by:
Based on observation, interviews and record review the facility failed to follow regulatory continued residency criteria for appropriateness in an Assisted Living Facility (ALF) for 2 out of 2 sampled residents (Residents #1 and #16).

The findings included:

1. In an observation of Resident #1 in the facility memory care unit on at approximately 12 PM the resident was sitting in a wheelchair and being attended to by a private duty aide. In an interview at that time with the Assistant Director of Nursing (ADON), he confirmed that Resident #1 had a right , , which is treated by a 3rd party provider, Home Health Agency nurse. The ADON stated that he was unfamiliar with the treatment or status of the right , . He stated that the resident had been on hospice service but then was discharged. He could not recall dates or details. The facility nursing progress notes for Resident #1 were requested for review.

Review of Resident #1's health care provider notes on indicated the resident has and developed , , which significantly was affecting his breathing and , and treated with , , . The note further indicates that the residents' prognosis is poor. The note indicates a hospice consultation was ordered. The note further shows an injury to the right , .

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A 010	Continued From page 5 Review of Hospice "facility admission/ discharge form" dated indicated Resident #1 was admitted to hospice services with a diagnosis of , body . Review of the facility's "Home Health /Hospice Visit Notes" provided by the hospice nurse dated , , , and indicate the resident is treated for a , on the right , . Review of the facility electronic nursing progress notes from thru date of survey, indicated no documentation of the right , development or status. Further review of the progress notes indicated a gap between to with no nursing progress note documentation. There is no documentation that the was improving with care treatment. Review of Resident #1's Health Assessment form dated indicated that the resident had medical history to include with , body . The form further indicated the resident is , bedridden, requires a mechanical soft diet and total care for Activities of Daily Living (ADL). Further review of the form indicated that Resident #1 had a , on that date. The form did not indicate that the resident was on hospice services. No documentation was available for review regarding Resident #1's discharge from hospice services. Review of Resident #1's Home Health Certification and Plan of Care start date	A 010		

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A 010	Continued From page 6 indicated diagnosis' including , history of right , with repair, history of repeat , history of , lymphedema, and a of the right . The resident is documented as alert, oriented to person only, continuous , unsteady on his , and using a wheelchair for mobility. Home health nursing services include care and assessment. Review of the facility's "Home Health /Hospice Visit Notes" dated indicated care treatment provided to right , with positive signs of healing. Review of the facility electronic nursing progress note for Resident #1 dated indicated the resident in the memory care bathroom. The private duty aide present at that time was unable to prevent the . Resident #1 was observed by staff to have coming from his and he sustained a golf ball sized lump to the forehead area. The resident was sent 911 to the hospital for evaluation. Review of Resident #1's hospital discharge instructions dated indicated the resident sustained orbital and was discharged to the facility with a to the right lateral . Further review of the facility electronic nursing progress notes from indicated no documentation of the worsening of the right upon readmission to the facility. No skin assessment was noted upon Resident #1's readmission. Review of the facility's "Home Health /Hospice Visit Notes" dated indicated the Home	A 010		

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A 010	Continued From page 7 Health Agency nurse provided the prescribed care to Resident#1's right , . The note further indicates a large area to the resident's left temple, cheek and . Review of Resident #1's Home Health Agency physician order dated indicated that nurses continue to perform care for non-healing right , , per physician orders. Review of Resident #1's hospital care clinic note dated indicated the resident has an , of the right , and , of the left heel. care orders are prescribed. Review of the facility electronic nursing progress notes from indicated no documentation of the worsening right , and development of the new right heel , Review of Resident #1's facility Service Plan dated indicates no / care concerns documented under diagnosis' section and no reference to care needs under service plan details section. Review of Resident #1's Home Health Agency physician order dated indicates care every other day for right , and , of left heel. Review of Resident #1's hospital care clinic note dated indicated assessment of , of right , and care orders were updated.	A 010		

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A 010	Continued From page 8 Review of Resident #1's hospital care clinic note dated indicated assessment of an ulcer, right , and , , , left heel. care orders are written for treatment 3 x week by nurse. Review of the facility's "Home Health /Hospice Visit Notes" dated indicated the resident was seen for Home Health Agency recertification. The note indicates Resident #1's right , measurements 2 x 2.5 x 1 cm with moderate drainage, and no signs of noted. care is being performed three times a week. Review of the facility electronic nursing progress notes dated , 9:31 AM indicated Resident #1 was found on the floor inside his room. Resident #1 was sent to the hospital for evaluation of a possible injury. Resident #1 returned the same day with no new orders. Review of the facility's "Home Health /Hospice Visit Notes" dated indicated care performed as ordered and a new was noted on Resident #1's right . Review of Resident #1's Home Health Agency physician order dated indicated right , ulcer care orders for 3 x week and as needed by the nurse. Further review of the note indicates to follow-up with the health care provider for care to right , three times a week. In an interview with the Assistant Director of Nursing (ADON) on at approximately 2:00 PM he was asked about the facility policy regarding nursing assessment of residents on readmission from the hospital. He stated that he	A 010		

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A 010	Continued From page 9 was unaware of a facility policy for nursing responsibilities on resident readmissions. He stated that he was unaware how Resident#1 had developed an on the right , and what treatment was ordered to treat the . He stated that the Home Health Agency nurse performs all care. When asked if he had observed Resident #1's during any prescribed treatments and he stated he had not. When questioned about the facility's 3rd party provider policy, he stated that the 3rd party provider staff are required to complete the "Home Health/ Hospice Visit Notes" form when they come into the building. When questioned what happened to the form, he stated that he or another nurse would review and then document the communication in the resident's electronic record. When questioned if that was occurring, he stated it was not. The ADON stated that he was employed at the facility for approximately six months. In an interview with the Home Health Agency nurse on at approximately 11:30 AM, the nurse stated that she completes a visit form when she provides prescribed treatment. She stated that she meets weekly with the Director of Nurses, along with the ADON and Administrator to discuss resident care and any concerns. She stated that Resident#1's worsening , and additional identifiied were discussed at the meetings. In an interview with the interim Administrator on at approximately 4:00 PM she stated that she was unable to locate the facility 3rd party provider policy. She stated the Director of Nurses was on leave and was unable to verify the facility's use of the communication form. The interim Administrator acknowledged that Resident	A 010		

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A	Continued From page 10 #1 did not meet the continued residency admission criteria with the development of an . She stated that there was a breakdown in the facility's communication regarding readmission processes. 2. On at 12:49 PM, Resident #16's representative stated that she moved the resident out of the facility against the facility's recommendations on as the resident required a higher level of care, a skilled nursing facility (SNF). She stated that upon admission to the SNF, the resident was identified as having a pressure injury (PI). She had not been notified of any while the resident was at the ALF. She stated that the facility Director of Nursing (DON) would not allow the resident to be transferred out of bed as she was heavy and required the assistance of two staff for transfers. She stated the resident was not on hospice. Review of the ALF record for Resident #16 revealed the following: (Progress Note) On / /SN (, , , / , , /skilled nursing) with (home health agency), drags her right , 2 assist, private duty started daily PM, hospital bed on order (Progress Note) Continues to be total care with transfer, mobility and ADLs (activities of daily living). Resident to be transferred to	A 010		

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A 010	Continued From page 11 rehabilitation facility Rehabilitation facility (SNF) with objective noted as "functional transfers sit to stand x2. Discharge planning needs per orders... prevention Health Assessment (AHCA Form 1823) dated notes "no pressure injuries , 3 or 4" and "appropriate for ALF" (Progress Note) "readmitted to ALF...assist of with transfers and ADLs...nonambulatory utilize wheelchair...no open areas noted (Progress Note) Resident moved out of facility Review of the Clinical Admission note dated from the SNF where the resident was moved to documents, "Left heel , /injury. was present on admission. Length (cm) 2.5; Width (cm) 3.2; Depth (cm) .1" Review of the email exchanges between the resident's representative and the facility Administrator and DON reveal the following: Representative to DON: "We were disappointed at our meeting a few weeks regarding (resident #16's) care. The conclusion that you could no longer move her out of her bed seemed sudden...while we appreciate your desire to "keep (resident #16) there" it is obviously not appropriate to have her in an environment where she is restricted to her bed 24/7 (all day and night)" Representative to Administrator: "you	A 010		

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A 010	Continued From page 12 had already notified us that you were no longer able to take care of (resident #16). In fact, at the meeting in with (the DON), she told us that you could no longer support (resident #16), and you immediately began confining her to her bed, 24/7, and generally stopped providing any level of care beyond feeding and diaper changing" Administrator to representative: "we could have care for (resident #16) under hospice services...I hope she is well and able to be out of bed with the use of the appropriate equipment" During review of the resident's record at the ALF, there was no documentation to show the resident was identified as being inappropriate for continued residency due to her requirement for total care and bedridden status without hospice services and a plan of care to ensure her additional care needs were being met. The Administrator and DON were not available for interviews to inquire about the resident's monitoring for continued appropriateness in the ALF. Class III	A 010		
A 030	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	A 030		

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A 030	Continued From page 13 admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions;	A 030		

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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 030	Continued From page 14	A 030		

8. The requirements for coordinating the delivery of services to residents by third party providers;
9. Assistive devices; and
10. Physical .
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside.

429.28 Resident bill of rights.-
(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:
(a) Live in a safe and decent living environment, free from and neglect.
(b) Be treated with consideration and respect and 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

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A 030	Continued From page 15 personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (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 , ,	A 030		

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A 030	Continued From page 16 for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the 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.	A 030		

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A 030	Continued From page 17 (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever 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	A 030		

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A 030	Continued From page 18 facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation, interviews and record review, the facility failed to ensure their policy and procedures for responding to grievances and to allow residents to recommend changes to facility procedures were implemented. The findings included: On at 11:30 AM, the recorded grievances for the facility from 2024 through 2025 were requested from the interim Administrator and were reviewed. There was a grievance dated by a resident's representative documented on the facility's Grievance/Concern Report that had no response noted. Additionally, there were four grievances in 2025 related to the same issue, an alleged violent and verbally resident in the secured unit, with supporting documentation on copies of emails from a staff member directed to the ADON (Assistant Director of Nursing or Resident Services Coordinator/RSC) and the DON (Director of Nursing or Resident Services Director/). There were no responses documented as to how the facility was the concerns on the forms dated , (2) and , or on the emails dated	A 030		

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A 030	Continued From page 19 (3), and . On at 12:15 PM, Resident #13 stated he had recorded grievances that he had submitted to the corporate office that were not resolved, specifically related to the menu not being followed and the quality of the food. During observation of the lunch served at this time, black beans and rice were observed as one of the two entrees, with tomato soup and peach cobbler. Review of the dietician's approved menu dated revealed the residents were to be served black bean burgers instead of the black beans and rice, spinach soup instead of the tomato soup and strawberry shortcake instead of the peach cobbler. During interview on at 1:00 PM with the Food Service Director from a different facility that was assisting, he stated the items were not served due to an "inventory" problem. A subsequent interview was conducted with Resident #13 at 1:30 PM on . The resident provided a copies of grievances that were submitted to the Regional Vice President (RVP) on or about . A response from the RVP by email dated directs the resident to "request a menu chat with (the chef)" and states that the "(management company) did not cut the food budget". A meeting with the resident was also planned. The resident's email response dated documents, "the quantity of beans we are served is ridiculous and we are often faced with an entree made from ultra processed smoked sausage and beans, with beans as a side dish...I speak with (the chef) every four weeks about the menu. He is well aware of my concerns...". During interview with the resident at this time, he also stated salad was not available	A 030		

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A 030	Continued From page 20 the evening of when he and 2 other residents requested it. Review of the approved menu confirmed salad was listed as a menu item to be served at that time. There was no grievance form completed for this resident's concerns, and no recording of them in the grievances maintained by the facility. The resident stated he was not aware of any grievance form utilized by the facility. Review of the facility's Policy and Procedure/Resident Grievance directives indicate the resident or representative should "discuss the complaint with the associate and Executive Director". Then, "If unable to resolve grievance with step 1, the grievance should be submitted in writing to Executive Director utilizing the Grievance/Concern Report. The Executive Director should provide a response to the resident and/or resident's responsible party within fourteen (14) days of receipt of the complaint". The procedure continues to direct steps for residents and/or their representatives to file complaints with the Regional Director Of Operations, then to the corporate office (Management company), then to the state agencies with required responses within 14 days by the facility. The lack of awareness of a grievance form by Resident #13, the absence of responses to the few forms that were submitted to the facility and the inappropriate resolution to Resident #13's concerns about the menu not followed with approved recipes by the dietician to ensure variety and palatability of meals indicates the facility's policy and procedures to address complaints were not followed or were ineffective. Class III	A 030		

Agency for Health Care Administration

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A 031	59A-36.007(6) FAC Resident Care - Third Party Services (6) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, , and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the , resident's needs. (c) The administrator or designee must ensure that: 1. Care coordination includes documented communications about the resident's condition and response to treatment or services ordered by the physician which may impact the resident's appropriateness for continued residency in the facility; 2. Communications occur at least once every 30 days and whenever there is a significant change in the resident's condition; and	A 031		

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A 031	Continued From page 22 3. If physician ordered treatments or services occur less often than once a month, communications must be conducted according to the ordered treatment or service schedule and whenever there is a significant change in the resident's condition. 4. When communication with the third party provider is unsuccessful, at least two attempts at communication on two separate days must be documented. Documentation must include the name of the person from the third party provider with whom contact was attempted, the method of communication, and the date and time of the attempts. This documentation must be included in the resident's record in accordance with the timeframes in subparagraphs 59A-36.007(6)(c)2. and 3. (d) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection. This Statute or Rule is not met as evidenced by: Based on record review and an interview, the facility failed to ensure there was a policy and procedure that requires third parties to coordinate with the facility regarding the resident's condition and the services being provided. The findings included: On at 3:00 PM, the policy procedure for the coordination of care with residents and third	A 031		

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A 031	Continued From page 23 parties was requested from the interim Administrator. There was no policy and procedure available for review at the time of the survey. The facility provided a policy and procedure to the Agency by email on at 6:11 PM. Class	A 031		
A 032	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement	A 032		

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A 032	Continued From page 24 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 interviews, the facility failed to ensure 2 out of 2 sampled residents (Resident #11 and #12) at risk for elopement had identification on their person checked once daily as part of their elopement	A 032		

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A 032	Continued From page 25 prevention policy and procedure. The findings included: On at 10:45 AM, Resident #11 and # 12 were observed ambulating in the secured unit without identification on them. Resident #11 and #12 were not interviewable due to . During interview with the ADON (Assistant Director Of Nursing or Resident Services Coordinator/RSC) at this time, he confirmed that they did not have identification on them and that there was no documentation to show daily checks by staff of their identification. Residents #11 and #12 had incident reports completed by the facility dated showing that the residents eloped from the secured unit into the facility's parking lot. The interim Administrator was present during these observations and interview. The facility provided no additional information for review at this time. Class III	A 032		
A 078	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 078		

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A 078	Continued From page 26 a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their 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	A 078		

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A 078	Continued From page 27 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 an interview, the facility failed to ensure 2 out of 3 sampled employees (Staff A & B) had submitted a written statement from a health care provider documenting that the employee does not have any signs or symptoms of communicable dated within six months prior to hire; and, failed to ensure 1 out of 3 sampled employees (Staff C) submitted an annual negative ( ) statement by a health care provider. The findings included: a) During review of the personnel file for Staff A, date of hire , a signed statement by a health care provider verifying this employee was free from all communicable , including , was not located in the file. b) During review of the personnel file for Staff B, date of hire , a signed statement by a health care provider verifying this employee was free from all communicable , including , was not located in the file.	A 078		

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THE HARRISON ASSISTED LIVING AND MEMORY CA	650 NW FORK RD STUART, FL 34994

(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 078	Continued From page 28 c) During review of the personnel file for Staff C, a statement documenting freedom from dated within the previous year by a health care provider could not be found. Staff C was hired on The interim Administrator was notified of these findings on at 5:00 PM. The facility provided no additional documentation of the required statements for review at this time. Class III	A 078		
A 081	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee 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.	A 081		

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A 081	Continued From page 29 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice 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	A 081		

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A 081	Continued From page 30 facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who 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:	A 081		

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A 081	Continued From page 31 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. This Statute or Rule is not met as evidenced by: Based on record review and an interview, the facility failed to ensure 2 out of 3 sampled staff (Staff A & B) had completed 2 hours of Preservice Orientation prior to interacting with residents; and, failed to ensure 2 out of 3 sampled staff (Staff A & B) who provides direct care to residents had received mandatory in-service training within 30 days of employment. The findings included: A. During review of the personnel file for Caregiver Staff A on , no certificate of a 2 hour Preservice Orientation showing completion	A 081		

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A 081	Continued From page 32 prior to interacting with residents could be found. Staff A was hired on . Review of the personnel file also revealed there was no documentation of the following required in-service training dated within 30 days of employment: 1. Facility's Emergency Procedures and Incident Reporting (1 hour required) 2. Residents' Rights (part of 1 hour required) 3. Activities of Daily Living (3 hours required) 4. Control (1 hour required) 5. Facility's Elopement Policy and Procedure B. During review of the personnel file for Caregiver Staff B on , no certificate of a 2 hour Preservice Orientation showing completion prior to interacting with residents could be found. Staff B was hired on . Review of the personnel file also revealed there was no documentation of the following required in-service training dated within 30 days of employment. 1. Facility's Emergency Procedures and Incident Reporting (1 hour required) The interim Administrator was notified of these findings at 5:00 PM on . The facility provided no additional documentation for review at this time. Class III	A 081		
A 082	59A-36.011(4) FAC Training - / (4)	A 082		

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A 082	Continued From page 33 / (/). Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on and , including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule. This Statute or Rule is not met as evidenced by: Based on record review and an interview, the facility failed to ensure 1 out of 3 sampled staff (Staff A) had completed and training within 30 days of employment. The findings included: During review of the personnel file for Caregiver Staff A on , no certificate of training in and could be found. Staff A was hired on . The interim Administrator was notified of these findings at 5:00 PM on . The facility provided no additional documentation for review at this time. Class III	A 082		
A 090	59A-36.011(11) FAC Training - (11) TRAINING. (a) Currently employed facility administrators,	A 090		

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A 090	Continued From page 34 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 an interview, the facility failed to ensure 2 out of 3 sampled staff (Staff A & B) had completed training in ( ) within 30 days of employment. The findings included: A. During review of the personnel file for Caregiver Staff A on , no certificate of training in could be found. Staff A was hired on . B. During review of the personnel file for Caregiver Staff B on , no certificate of training in could be found. Staff B was hired on . The interim Administrator was notified of these findings at 5:00 PM on . The facility provided no additional documentation for review at this time. Class III	A 090		

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AN277	Continued From page 35	AN277		
AN277	59A-36.022(2) FAC LNS - Resident Care Standards (2) RESIDENT CARE STANDARDS. (a) A resident receiving limited nursing services in a facility holding only a standard and limited nursing services license must meet the admission and continued residency criteria specified in Rule 59A-36.006, F.A.C. (b) In accordance with Rule 59A-36.010, F.A.C., the facility must employ sufficient and qualified staff to meet the needs of residents requiring limited nursing services based on the number of such residents and the type of nursing service to be provided. (c) Limited nursing services may only be provided as authorized by a health care practitioner's order, a copy of which must be maintained in the resident's file. (d) Facilities licensed to provide limited nursing services must employ or contract with a nurse(s) who must be available to provide such services as needed by residents. The facility's employed or nurse must coordinate with third party nursing services providers to ensure resident care is provided in a safe and consistent manner. The facility must maintain documentation of the qualifications of nurses providing limited nursing services in the facility's personnel files. (e) The facility must ensure that nursing services are conducted and supervised in accordance with Chapter 464, F.S., and the prevailing standard of practice in the nursing community. This Statute or Rule is not met as evidenced by: Based on interview and record review the facility failed to meet the regulatory guidance for staffing under Limited Nursing Services (LNS) licensure. This was evidenced by the failure to employ or	AN277		

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AN277	Continued From page 36 contract with a professional nurse to conduct monthly nursing assessments and coordinate nursing services to residents receiving LNS. The findings include: In an interview with the interim Administrator on at approximately 4 PM she stated that the facility had not yet designated a registered nurse to provide LNS licensure services as needed or to coordinate with third party providers to ensure resident care is provided. The interim Administrator stated that the facility's current renewal re-licensure application indicates the request for the Extended Congregate Care license to be dropped and replaced with an initial LNS license. Review of the facility's re-licensure application indicated a specialty license request for Limited Nursing Services (LNS). Class III	AN277		

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CZ830	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider	CZ830		

AHCA Form 3020-0001

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

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CZ830	Continued From page 1 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	CZ830		

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CZ830	Continued From page 2 approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on record review and an interview, the facility failed to submit their Comprehensive Emergency Management Plan (CEMP)annually to the county emergency planning department for review and approval. The findings included: On at 11:00 AM, the interim Administrator confirmed during interview that the last CEMP that was approved by the county was dated as the previous administration had not yet submitted the current year's plan for approval. The plan is approved by the county for one (1) year, with the requirement that the facility resubmit the plan at least annually. Review of the approval letter provided by the county for this plan revealed it was dated . An email received from the county emergency planning department dated at 8:24 AM noted that the facility had not sent the annual CEMP for approval since the last plan approval expired on . The facility provided no additional documentation for review at this time. Unclassified	CZ830		
CZ875	430.5025(4 &) / ; Training (4) Employees of covered providers must complete the following training for 's	CZ875		

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

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CZ875	Continued From page 4	CZ875		

additional training must include, but is not limited to, behavior management, promoting the person ' s independence in activities of daily living, and skills in working with families and caregivers.
(d) Within 7 months after beginning employment for a nursing home, an assisted living facility, an adult family-care home, or an adult day care center, each employee who provides personal care must complete 3 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, skills in working with families and caregivers, group and individual activities, maintaining an appropriate environment, and ethical issues.
(e) For an assisted living facility, adult family-care home, or adult day care center that advertises and provides, or is designated to provide, specialized care for persons with 's or related forms of , in addition to the training specified in paragraphs (a) and (b), employees must receive the following training:
1. Within 3 months after beginning employment, each employee who provides personal care to or has regular contact with the residents or participants must complete the additional 3 hours of training as provided in paragraph (d).
2. Within 6 months after beginning employment, each employee who provides personal care must complete an additional 4 hours of -specific training. Such training must include, but is not limited to, understanding and related forms of , the stages of 's , communication strategies, medical information, and stress management.
3. Thereafter, each employee who provides personal care must participate in at least 4 hours

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CZ875	Continued From page 5	CZ875		

of continuing education each calendar year through contact hours, on-the-job training, or electronic learning . For this subparagraph, the term "on-the-job training" means a form of direct coaching in which a facility administrator or his or her designee instructs an employee who provides personal care with guidance, support, or -on experience to help develop and refine the employee's skills for caring for a person with 's or a related form of . The continuing education must cover at least one of the topics included in the -specific training in which the employee has not received previous training in the previous calendar year. The continuing education may be fulfilled and documented in a minimum of one quarter-hour increments through on-the-job training of the employee by a facility administrator or his or her designee or by an electronic learning , chosen by the facility administrator. On-the-job training may not account for more than 2 hours of continuing education each calendar year.
(f)1. An employee provided, assigned, or referred by a health care services pool must complete the training required in paragraph (c), paragraph (d), or paragraph (e) that is applicable to the covered provider and the position in which the employee will be working. The documentation verifying the completed training and continuing education of the employee, if applicable, must be provided to the covered provider upon request.
2. A health care services pool must verify and maintain documentation as required under s. 400.980(5) before providing, assigning, or referring an employee to a covered provider.
(7) For a certified nursing assistant as defined in s. 464.201, training hours completed as required under this section may count toward the total

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969790	A. BUILDING: _____ B. WING _____	07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HARRISON ASSISTED LIVING AND MEMORY CA	650 NW FORK RD STUART, FL 34994

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ875	Continued From page 6 hours of training required to maintain certification as a nursing assistant. (8) For a health care practitioner as defined in s. 456.001, training hours completed as required under this section may count toward the total hours of continuing education required by that practitioner's licensing board. (9) Each person employed, , or referred to provide services before , , , must complete the training required in this section before , . Proof of completion of equivalent training completed before , , , shall substitute for the training required in subsection (4). Each person employed, , or referred to provide services on or after , , may complete training using approved curriculum under paragraph (5)(d) until the effective date of the rules adopted by the department under subsection (6). This Statute or Rule is not met as evidenced by: Based on record review and an interview, the facility failed to ensure that 2 of 3 sampled staff (Staff A & B), in this facility that advertises and provides special care for persons with or related forms of (ADRD), had completed the required training in ADRD. The findings included: A. The personnel file for Caregiver Staff A was reviewed on for training in ADRD and did not contain documentation of all required training. Staff A was hired on . Staff C was required to complete 1 hour of training within 30 days of hire, 3 hours of additional training within 3 months of hire, and 4 more hours of training within 6 months of hire. Staff A had two	CZ875		

Agency for Health Care Administration

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CZ875	Continued From page 7 certificates showing 4 hours of training completed (Part I and II, 2 hours each) on (4 hours less than what was required by , 6 months after hire). B. The personnel file for Caregiver Staff B was reviewed on for training in ADRD and did not contain documentation of all required training. Staff B was hired on . Staff B was required to complete 1 hour of training within 30 days of hire, 3 hours of additional training within 3 months of hire, and 4 more hours of training within 6 months of hire. Staff B had a Level II ADRD training certificate showing 4 hours completed on (4 hours less than what was required by , 6 months after hire). Staff B completed 4 hours of training (Level I ADRD) on , 3 months late. The interim Administrator was notified of these findings at 5:00 PM on . The facility provided no additional documentation for review at the time of the survey. Unclassified	CZ875		