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
	AL11970392	A. BUILDING: _____ B. WING _____	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE NONA	10298 SAVANNAH PARK DR ORLANDO, FL 32832

(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
ZZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the , , are enrolled in the national retained print notification program at the Federal Bureau of Investigation: 1. A person with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. 2. Effective , , , or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity. (c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse. 1. Before , , , initial status and any changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person ' s status has been made. 2. Effective , , , initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person ' s status has been made.	ZZ814		

AHCA Form 3020-0001

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

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ZZ814	Continued From page 1 (d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic , submission to the Department of Law Enforcement. The registration must include the person ' s full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on review of the facility's background screening clearinghouse and interviews, the facility failed to report the employment status within 5 business days for 1 of 5 sampled staff (I). Findings: On at 3:45 PM review of the facility's background screening roster revealed caregiver I listed as an active employee. On at 9:55 AM, the administrator stated caregiver I still worked at the facility. Review of the facility's staff schedule indicated the last day caregiver I worked was on . On at 11:16 AM, the RCC reviewed the schedule and confirmed was the last day caregiver I worked, and she was no	ZZ814		

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ZZ814	Continued From page 2 longer employed at the facility. The administrator was asked who was responsible for updating the background clearinghouse roster. On at 11:34 AM, the administrator stated right now it goes through our corporate office, but it will be me once I have access to the system. (photographic evidence obtained) Unclassified	ZZ814		
ZZ875 SS=D	430.5025(4 &) / ; Training (4) Employees of covered providers must complete the following training for 's 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	ZZ875		

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ZZ875	Continued From page 3	ZZ875		

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 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,

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ZZ875	Continued From page 4 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 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	ZZ875		

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ZZ875	Continued From page 5 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 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).	ZZ875		

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ZZ875	Continued From page 6 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 5 of 5 sampled caregivers (B, D, F, G, I) completed a 1-hour training on . and related forms of (ADRD) provided by the department of elderly affairs within 30 days after beginning employment. Findings: Review of caregiver B's personnel record revealed a hire date of . Caregiver D was hired on . Caregiver F was hired on . Caregiver G was hired on . Caregiver I was hired on . None of their personnel documents included a 1-hour training on ADRD provided by the department of elderly affairs. On at 11:35 AM, the administrator said she did not have proof of the training. Class III	ZZ875		
A 000	Initial Comments Five complaint investigations #2025008214, #2025008900, #2025009178, #2025008656 and generator monitoring were conducted at Hearthstone Nona and Memory Care on	A 000		

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A 000	Continued From page 7 - . The facility had deficiencies at the time of the visit.	A 000		
A 008 SS=D	429.26( ) FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner's direct observation of the patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form, reflecting the resident's condition on the date the examination is performed, becomes a permanent part of the facility's record of the resident and must be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and	A 008		

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A 008	Continued From page 8 Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or , , nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator	A 008		

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A 008	Continued From page 9 whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of , , require such assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a -to- medical examination completed by a health care practitioner as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 days before or within 30 days after the individual's admission to a facility pursuant to Section 429.26(5), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations, 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living, 3. Any nursing or services required by the individual, 4. Any special diet required by the individual, 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication, 6. Whether the individual has signs or symptoms of , , , or any other communicable , which are likely to be transmitted to other residents or staff, 7. A statement on the day of the examination that, in the opinion of the examining health care practitioner, the individual's needs can be met in an assisted living facility; and,	A 008		

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A 008	Continued From page 10 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care practitioner. (b) When a health care practitioner conducts a medical examination, the examination must be recorded on the practitioner's form or on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, , , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-13531. Faxed or electronic copies of the completed form are acceptable. If AHCA Form 1823 is used, the form must be completed as instructed. 1. If the health care practitioner's form does not include all the examination items on AHCA Form 1823 or if AHCA Form 1823 is not completed fully, then the omitted items may be obtained by the administrator or designee either orally or in writing from the health care practitioner. The missing or omitted information must be obtained and documented in the resident's record within 30 days after the resident's admission to the facility. 2. Omitted or missing information received orally must include the name of the health care practitioner, the name and signature of the administrator or designee recording the information, and the date the information was provided. (c) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (d) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care	A 008		

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A 008	Continued From page 11 Services (CARES) program may be substituted for the medical examination requirements of Section 429.26, F.S. and this rule. (e) Any orders issued by the health care practitioner conducting the medical examination for medications, nursing services, treatments, , , , or therapeutic diets, may be attached to the health assessment. A health care practitioner may attach a DH Form 1896, Florida Form, for residents who do not wish to be administered in the case of or . (f) 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 the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain documentation to indicate 2 of 12 sampled residents (#13 & #15) were examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility. Findings:	A 008		

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A 008	Continued From page 12 1. Review of resident #15's record revealed a facility admission date of . The record did not have documentation to indicate the resident was examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility. On at 12:40 PM, the director of nursing (DON) said there was no health assessment form (1823) or other documentation to indicate the required examination was done. 2. Review of resident #13's record revealed a facility admission on . Further review revealed the records did not contain an admission 1823 health assessment. The director of nursing was asked if the facility obtained an 1823 for resident #13's admission to the facility. On at 12:40 PM, the director of nursing stated, whatever you have is in his chart. A follow up was conducted with the director of nursing regarding resident #13's missing 1823 health assessment. On at 3:10 PM, the director of nursing stated, I'll look again, but it's not there so it's safe to say the facility doesn't have it. Class III	A 008		

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A 010	Continued From page 13	A 010		
A 010 SS=D	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. (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	A 010		

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A 010	Continued From page 14 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 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.	A 010		

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	AL11970392	A. BUILDING: _____ B. WING _____	07/30/2025

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A 010	Continued From page 15 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 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	A 010		

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A 010	Continued From page 16 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, 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 observations, resident record reviews and interviews, the facility failed to obtain a new AHCA Form, 1823 Health Assessment completed by the healthcare provider for continued	A 010		

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A 010	Continued From page 17 residency after a significant change for 4 of 12 sampled residents (#3, #4, #14, #15) as required in an assisted living facility (ALF). Findings: On at 9:25 AM during the entrance conference, the director of nursing identified resident #3, #4 and #14 as receiving hospice services. 1. Review of resident #3's 1823 health assessment indicated a medical history of , (, , ,), and (, , ,) as nursing services. There was no indication of hospice services. Further review of resident #3's hospice initial care plan revealed an admission on . A facility note on at 6:35 PM read, spoke with cornerstone hospice about the correct order for resident #3's meds. A facility note on at 3:58 PM read, nurse was notified with cornerstone hospice that doctor has approved all prescriptions. A facility note on at 7:47 PM read, nurse will call cornerstone hospice. A facility note on at 4:12 PM, read nurse assessed resident #3's skin with cornerstone hospice. A facility note on at 12:55 PM read, resident moved to Hearthstone into our connection's neighborhood, secured, contact cornerstone hospice.	A 010		

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A 010	Continued From page 18 The director of nursing was asked if the facility obtained a new 1823 for resident #3's hospice admission. On at 12:40 PM, the director of nursing stated, whatever you have is in his chart. We do not have the 1823 for hospice. 2. Review of resident #4's record revealed a facility admission date of . His medical history included , , , and mild . A 1823 indicated he needed assistance with bathing, , grooming, and toileting (activities of daily living (ADLs.) Resident #4's care plan, last updated on , indicated he needed with bathing, , and toileting and with grooming and . On at 11:05 AM, resident #4 was in his recliner in his room. His were closed. He was slow to arouse. He said he was sleepy. On at 10:07 AM, caregiver D said resident #4 needed total care with ADLs. On at 3:20 PM, the resident care coordinator said resident #4 needed a lot of assistance. On at 11:55 AM, caregiver G said resident #4 needed total care. 3. Review of resident #15's record revealed a facility admission date of . Her medical history included . The 1823 form was not completed.	A 010		

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A 010	Continued From page 19 Resident #15's care plan, last updated on , indicated she needed with bathing and and minimal assistance with and toileting. There was no documentation regarding grooming assistance. On at 11:24 AM, resident #15 said she can't stand and can't use the toilet. She wears an brief. On at 11:15 AM, caregiver B said both residents #4 and #15 needed total care with ADLs. On at 1:02 PM, caregiver A said both residents #4 and #15 needed total care with ADLs. On at 2:20 PM, caregiver E said both residents #4 and #15 needed total care with ADLs. On at 2:25 PM, the administrator said the DON conducted an assessment on each resident one month after their admission, quarterly thereafter, and upon a significant change. The resident's care plan was updated to reflect the assessment findings. She said staff did not tell her residents #4 and #15 needed total care. 4. Review of resident #14's record revealed a facility admission date of . On the resident was admitted to hospice services. The only 1823 in the record was dated .	A 010		

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A 010	Continued From page 20 On at 12:40 PM, the DON said a new 1823 was not completed when the resident was admitted to hospice. Class III	A 010		
A 030 SS=D	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (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	A 030		

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A 030	Continued From page 21 and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 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	A 030		

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A 030	Continued From page 22 residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, 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	A 030		

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A 030	Continued From page 23 provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , 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	A 030		

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A 030	Continued From page 24 relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and 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	A 030		

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A 030	Continued From page 25 must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or 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, record review, and interview, the facility failed to treat 1 of 12 sampled residents (#4) with consideration when it failed to follow the resident's care plan for daily bedmaking and failed to follow its policy on resident complaints. Findings: 1. On at 11:05 AM, resident #4 was in his	A 030		

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A 030	Continued From page 26 recliner in his room. His , were closed. He was slow to arouse. He said he was sleepy. His mattress had no linen and was unmade. On at 2:58 PM, resident #4's bed was still not made. On at 3:05 PM, caregiver D, who was assigned to resident #4, said he normally worked in memory care and was not familiar with the assisted living processes, which was why he could not answer why resident #4's bed was not made. He said that usually the person who gets the resident out of bed makes it. Caregiver D said he and another caregiver got resident #4 out of bed that morning. He repeated he did not know the procedures in assisted living and assumed everyone else knew what was going on. He did see the bed was not made. Resident #4's care plan indicated the care team would make sure the resident's room was clean with daily bedmaking during the 7 AM to 3 PM shift. 2. Review of the minutes from the resident council meetings held on , , and revealed there was no documentation to indicate the facility addressed concerns brought up during the meetings. The facility's complaint resolution policy and procedure, effective , indicated a grievance was not limited to a formal, written grievance process but may include a resident's verbalized complaint to community staff or during resident/family meetings. A written record of complaints with a resolution will be maintained by the executive director.	A 030		

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A 030	Continued From page 27 On at 8:50 AM, the administrator said she did not have documentation for the complaints being resolved. On at 9:15 AM, the life enrichment director said she took the minutes during the meetings. Her only responsibility was to forward the complaints to the appropriate manager. She did not know if the complaints were resolved. Class III	A 030		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change.	A 052		

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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 052	Continued From page 28 (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his	A 052		

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	AL11970392	A. BUILDING: _____ B. WING _____	07/30/2025

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A 052	Continued From page 29 or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the	A 052		

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A 052	Continued From page 30 resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, record review, and	A 052		

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A 052	Continued From page 31 interview, the facility failed to ensure the unlicensed caregiver (A) who assisted 1 of 2 sampled residents (#14) with medications gave the correct dose. Findings: Observations made during a medication pass on at 10:30 AM revealed unlicensed caregiver A gave resident #14 only 1 tablet of , and when two tablets were prescribed. The resident's family member was present and had to intervene to tell the caregiver to give the correct doses. On at 12:35 PM, unlicensed caregiver A said she was nervous when she did not give the corrected doses. Review of the caregiver's personnel record revealed there was no proof she received training in assisting with self-administration of medications. Class III	A 052		
A 053 SS=D	59A-36.008(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION. (a) For facilities that provide medication administration, a staff member licensed to administer medications must be available to administer medications in accordance with a health care provider's order or prescription label. (b) Unusual reactions to the medication or a significant change in the resident's health or behavior that may be caused by the medication must be documented in the resident's record and reported immediately to the resident's health care	A 053		

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A 053	Continued From page 32 provider. The contact with the health care provider must also be documented in the resident's record. (c) Medication administration includes conducting any examination or other procedure necessary for the proper administration of medication that the resident cannot conduct personally and that can be performed by licensed staff. (d) A facility that performs clinical laboratory tests for residents, including ⌣ testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Chapter 483, Part I, F.S. A valid copy of the federal CLIA Certificate must be maintained in the facility. A federal CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a federal CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents' equipment. Information about the federal CLIA Certificate is available from the Laboratory and In-Home Services Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)412-4500. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a staff member licensed to administer medications was available in accordance with a health care provider's order for 1 of 12 sampled residents (#14.) Findings: On at 10:12 AM, resident #14's family member said the resident was prescribed injections and the family member had to	A 053		

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A 053	Continued From page 33 administer it herself because the facility did not have a nurse. On a health care provider ordered 300 milligrams (mg)/3 milliliter vial, inject 22 mg , daily until Documentation on the medication observation record (MOR) revealed the family member administered it. On at 9 AM, the findings were discussed with the administrator, who could not provide an explanation. On at 10:39 AM, nurse J, the director of health and wellness at that time, said she told the family member she was the only employed nurse and would not always be available, so the family member had to administer the medication. Class III	A 053		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be	A 054		

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A 054	Continued From page 34 immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to follow its medication errors policy and procedure when 1 of 12 sampled residents (#14) was given medication that was not prescribed by a health care provider. Findings: Review of resident #14's MOR revealed she received 200 mg daily from through . However, this medication was never prescribed by a health care provider. is a medication used to treat irregular heartbeats. Review of a facility incident report revealed the facility's investigation determined the error occurred because of a dispensing error by the pharmacy. On at 10:12 AM, resident #14's family	A 054		

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A 054	Continued From page 35 member said the resident did not go to the hospital and did not have negative effects from receiving the . The medication errors policy and procedure, effective , , indicated all relevant details of the error/incident will be entered in the electronic medication administration record (eMAR) and observation note completed including the following: medication given in error, date the error occurred, time the error occurred, dose of any medication that was given in error, description of error that occurred, and action taken. Neither the eMAR nor the residents' observation notes had this information. On at 8:50 AM, the DON confirmed the findings and was unable to provide additional documentation. Class III	A 054		
A 084 SS=D	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule	A 084		

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A 084	Continued From page 36 requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, , dosage forms, and , , , and dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility	A 084		

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A 084	Continued From page 37 employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with syringes that are prefilled with the proper dosage by a pharmacist and , that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection; i. Assist with ; j. Use a to perform testing; k. Assist residents with and continuous positive airway pressure (CPAP) devices, excluding the titration of the levels; l. Apply and remove stockings and hosiery; m. Placement and removal of bags, excluding the removal of the or manipulation of the site; and, n. Measurement of rate, temperature, and rate. (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online. (d) Trained unlicensed staff who, prior to the	A 084		

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A 084	Continued From page 38 effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training This Statute or Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure 1of 5 of unlicensed caregiver (A) who provides assistance with self-administration of medications completed the initial 6-hour training and a 2hour continuing education annually. Findings: Review of unlicensed caregiver A's record revealed a hire date of . There was no documented evidence of a 6-hr. initial training or a 2-hr. continuing education annually was completed prior to assisting with self-administration of medication. On at 12:52 PM, the administrator was	A 084		

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A 084	Continued From page 39 asked if there was any additional training for unlicensed caregiver A. On at 9:55 AM, a follow up request was made for unlicensed caregiver A's medication pass assistance with self-administration medication training. On at 12:30 PM, the administrator confirmed the findings, and no additional documentation was provided. Class III	A 084		
A 093 SS=D	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a	A 093		

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A 093	Continued From page 40 licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to	A 093		

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A 093	Continued From page 41 document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of ˻ the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local	A 093		

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A 093	Continued From page 42 disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observations, facility's record reviews, and interviews, the facility failed to ensure 1 of 20 sampled residents (#13) was served during lunch and 2) failed to have menus posted or readily available. Findings: 1. On at 11:50 AM, observation of the memory care dining area during lunch revealed the resident's sitting at tables preparing for lunch. Observation revealed caregiver C pushing a cart to each table with two different plates of food, asking the residents which option they preferred, and returning to the kitchen area in memory care to prepare their plates. On at 12:35 PM, Further observation revealed resident #13 still sitting at the table with 2 other residents. The 2 residents had received their food and was eating while resident #13 continued to wait. Resident #13 was asked if she was eating today and if she ordered a meal from the kitchen. On at 12:38 PM, resident #13 replied yes, indicating she was eating today and ordered chicken from the kitchen. Observation revealed the chef entering the memory care unit and was asked if he knew why resident #13 had not eaten. On at 12:39 PM, the chef stated I was not aware resident #13 had not eaten. I was only	A 093		

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	AL11970392	A. BUILDING: _____ B. WING _____	07/30/2025

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A 093	Continued From page 43 coming to memory care to see if they needed any more broccoli. I saw the chicken ⌄ and fries, but was unaware it was for a resident in memory care. He continued by asking the staff observed in the dining room, no one in , , if resident #13 had eaten lunch? On at 12:42 PM, caregiver D and several other staff replied, yes resident #13 had lunch and she now is eating her dessert. The staff was made aware during the observation that resident #13 never received a meal. She was served dessert when caregiver C entered the memory care unit with a cart after returning from the main kitchen (located in assisted living). The staff was also made aware that resident #13 informed the surveyor she ordered a meal from the kitchen. On at 12:50 PM, caregiver C stated, when I showed resident #13 the two plates of food today. She stated she didn't want it and asked for chicken ⌄ and fries. I went to the kitchen to place the order, picked up the menu for the surveyor, but did not return to pick up resident #13's meal. On at approximately 12:52 PM, Observation revealed the chef leaving memory care and returning with resident #13's meal from the main kitchen. On at 1:15 PM, the chef stated we've put something in place to ensure that what happened with resident #13 does not happen again to her or any other residents.	A 093		

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A 093	Continued From page 44 2. On at 11:40 AM, observation in the memory care unit did not revealed today's menus posted. The resident care coordinator (RCC) was asked to provide the location of the menu posted for review. On at 11:45 AM, the RCC stated here's the breakfast menu (observed lying on the counter). The menus for lunch and dinner are up front (pointing to the assisted living (AL) dining area near the foyer). He continued by asking the surveyor "do you wanted to go out to take a look." The RCC was made aware that the regulations states planned menus are to be posted or easily available to residents. The residents who live and dine in a secured memory care unit menus are not easily accessible for daily review when posted in AL. On at approximately 12:00 PM, caregiver C went to the AL dining area to obtain a menu for review. (photographic evidence obtained) Class III	A 093		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth,	A 162		

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A 162	Continued From page 45 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A ◡ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their ◡ recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that ◡ not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if	A 162		

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A 162	Continued From page 46 such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , { }, CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No =Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is	A 162		

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A 162	Continued From page 47 a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: interview the facility failed to obtain a ⌄ record that is initiated on admission for 1 of 3 sampled residents (#13) receiving assistance with the activities of daily living (ADL) have their ⌄ recorded semi-annually. Findings: Review of resident #13's record revealed a facility admission on . Further review revealed the records did not indicate the required assistance needed with ADLs.	A 162		

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A 162	Continued From page 48 The director of nursing was asked to provide the ␣ log for review. On at 3:30 PM, review of the ␣ tracking and variance report generated on revealed as through resident #13 had not been ␣. The record revealed no documentation with an indication resident #13 was receiving hospice services and no documentation from her physician requesting in writing that ␣ not be taken. On at 3:30 PM, the director of nursing confirmed the findings and provided no additional documentation. (photographic evidence obtained) Class III	A 162		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container.	A 056		

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A 056	Continued From page 49 (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable.	A 056		

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A 056	Continued From page 50 (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to make every reasonable effort to ensure that prescriptions for 2 of 12 sampled residents (#24 & #25) were refilled in a timely manner. Findings: 1. Review of resident #24's health	A 056		

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A 056	Continued From page 51 assessment form (1823) revealed resident needed assistance with self-administration of medication. Her medical history included and ( ). On at 4:19 PM the resident said she did not get one of her medications this past weekend, however, the resident could not recall the name of the medication. Review of the medication observation record (MOR) revealed on the resident did not receive 81 mg tablet, one tablet by daily and 40 mg capsule, one capsule by daily before meals. The MOR note indicated medication not available and pending delivery from the pharmacy. On at 5:07 PM the findings were discussed with the director of nursing (DON), who said the facility was waiting for cycle to fill from the pharmacy over the weekend. There was no documentation to indicate the facility made efforts to refill the medications prior to running out. 2. Review of resident #25's 1823 revealed the resident needed assistance with self-administration of medication. Her medical history included Review of the MOR revealed the resident received 25 mg tablet, one tablet by daily. The mediation was only received on , and On at 9:35 AM the findings were discussed with the DON who said she was not informed there was issue with obtaining the	A 056		

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A 056	Continued From page 52 medication. The DON was given an opportunity to provide additional documentation; no additional documentation was provided. The facility's refill policy revised indicated all medications must be reordered from the pharmacy in a timely manner. Class III	A 056		