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
	AL11966042	A. BUILDING: _____ B. WING _____	09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS	3800 62ND AVENUE NORTH PINELLAS PARK, FL 33781

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A re-licensure survey and complaint investigation (2025009084, 2025012420) was conducted at Magnolia Gardens Assisted Living on . Deficiencies were identified at the time of the survey. A Class I deficiency was found at Tag A0025. A Class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, , , or to a resident receiving care in a facility. Magnolia Gardens Assisted Living failed to provide adequate personal supervision and oversight required for each resident, to include awareness of general health, safety, and well-being to prevent elopements. The Class I noncompliance began on , , . The facility's Administrator was notified of the Class I noncompliance on at 8:30 p.m. The census at the start of the survey was 101. The following is a description of the deficiencies found at the time of the visit.	A 000		
A 025 SS=K	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician	A 025		

AHCA Form 3020-0001

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

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A 025	Continued From page 1 when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's	A 025		

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A 025	Continued From page 2 family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interviews, and record review the facility failed to provide adequate personal supervision and oversight required for each resident, to include awareness of general health, safety, and well-being for three (Resident #1, Resident #2, and Resident #20) of three sampled residents. This lack of supervision, oversight and general awareness of resident whereabouts resulted in three elopement events within a five-month period. The facility's lack of action before and after the elopement events placed all residents at immediate risk of harm. Findings included: On between 8:03 a.m. and 8:08 a.m., an observation was conducted outside the facility's front entrance. The facility front door was locked, no staff were visible, and an after-hour phone number was posted. The agency surveyors rang the doorbell, but no response was received. A call was placed using the posted after-hours phone number. The phone call connected to an automated greeting that stated to stay on the line then preceded to ring and was not	A 025		

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A 025	Continued From page 3	A 025		

answered. A resident attempted to pry the doors apart from inside the building to allow surveyor access. An alarm sounded when the doors opened but no staff responded to the alarm. Staff I was found sitting in the medication room down the hall.

On at 8:05 a.m., an interview was conducted with Staff I. Staff I stated that Resident #1 eloped from the facility last week. Staff I stated Resident #1 was waiting for her daughter and then off.

On at 8:27 a.m. an interview was conducted with Staff D. Staff D stated an unknown resident eloped from the facility two weeks prior. Staff D also stated there were helicopters and police involved in the search . Additionally, Staff D said staff D had not participated in elopement drills. Staff D was hired on .

On at 11:40 a.m. a phone interview was conducted with Resident #1's family member. Resident #1's family member stated, after calling Resident #1 and stating family member was on the way to get Resident #1 for lunch, Resident #1 slipped out the side door. The family member stated the cops and helicopters were looking for Resident #1 for two to four hours before they found Resident #1 in a car.

On at 1:39 p.m. a phone interview was conducted with a high-ranking official with the local emergency services. The official with the local emergency services stated that there was a resident who went missing from the facility on . The official stated after an hour-long search, Resident #1 was located at the apartment next to the facility in a car.

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A 025	Continued From page 4 On at 2:23 p.m. an interview was conducted with the Administrator. The Administrator stated Resident #1 left the facility without the staff's knowledge and after police and staff did a room by room check, Resident #1 was found in a parked car on the facility premises, in a little parking lot by dumpsters. The Administrator said Resident #1 needed more frequent checks and redirection. Additionally, the Administrator said Resident #1 was upon admission and the Administrator had already discussed concerns with Resident #1's family who wanted Resident #1 to stay in the facility. The Administrator stated Resident #1 required checks hourly due to elopement risk. Furthermore, The Administrator said there was no documentation that the facility staff completed hourly checks after Resident #1's elopement. The Administrator stated Resident#1's family member got an air tag for Resident #1 that Resident #1 kept taking off. On a record review of a law enforcement incident report dated was conducted, regarding Resident #1. The report revealed a call was received on at 12:22 p.m. for a missing resident last seen at 11:20 a.m.. The report listed the call was completed with Resident #1 found at 2:54 p.m. sitting in a gray vehicle of an unknown party. (photographic evidence obtained) On at 2:35 p.m. an interview was conducted with the Regional Director of Operations. The Regional Director of Operations stated the facility cannot provide proof that hourly checks were conducted for Resident #1. On a record review of Resident #1's Agency for Healthcare Administration Resident	A 025		

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A 025	Continued From page 5 Health Assessment form 1823 (1823) dated , revealed Resident #1 had the following: " Medical history and diagnoses: " or behavioral status: "combative per daughter, , , leaves stove on and forgets to turn off." " Nursing/Treatment/ , , Service Requirements: nursing for . " Special Precautions: . " Elopement Risk: No (photographic evidence obtained) On at 4:37 p.m. an interview was conducted with Staff G. Staff G stated Resident #1 left the facility and was gone 40 minutes before being found in a stranger's car by staff. Additionally, Staff G said they had not participated in elopement drills. Staff G was hired on . On at 4:49 p.m. an interview was conducted with Staff E. Staff E stated Resident #1's family members came in to visit Resident #1. When Resident #1 could not be located, Staff E and Staff G began a room search that extended to outside of the facility. Staff E said law enforcement arrived and helped search and the resident was located in a stranger's parked car in the 55 and up apartment , next to the facility. Additionally, Staff E stated after the Resident #1 returned the facility Resident #1 continued exit seeking behavior by looking for a key to leave the facility again on Monday, . Staff E stated Resident #1 and was and needed more supervision. On a record review of a law enforcement incident detail report dated	A 025		

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A 025	Continued From page 6 at 1:09a.m. for Resident #2 was conducted. The report revealed an incident occurred on at 1:09 a.m. Resident #2 called 911. Local law enforcement found Resident #2, barefoot with a walker across the street from the facility. Resident#2 was returned to the facility by a law enforcement officer at 1:19 a.m. (photographic evidence obtained) On at 6:00 p.m. an interview was conducted with the Administrator. The Administrator stated she was made aware on that Resident #2 went out at 1:00 a.m. barefoot to smoke. The Administrator stated somebody brought Resident #2 to the facility and Resident #2 appeared disoriented upon her return. The Administrator stated Resident #2 must have gone out the door, and no staff heard the alarm. The Administrator stated that Resident #2 was gone approximately fifteen minutes. Resident #2's Power of Attorney (POA) came into the facility later that day and stated Resident #2 was not herself. On at 6:26 p.m. an interview was conducted with Resident #2. Resident #2 stated something happened the night of but could not remember any of it. Resident #2 remembered feeling weird because Resident #2 was not using correctly. Additionally, Resident #2 did not remember leaving the facility or why. Resident #2 stated it could not have been due to going out to smoke because Resident #2 quit smoking on after being placed on On a record review of Resident #2's Agency for Healthcare Administration Resident Health Assessment form 1823 (1823) dated , revealed Resident #2 had the	A 025		

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A 025	Continued From page 7 following: - Medical history and diagnoses: [illegible] ( ) - [illegible] dependent, [illegible] ( ), [illegible] [illegible] type. - [illegible] or behavioral status: [illegible] - Elopement Risk: No (photographic evidence obtained) On A record review of facility observation notes for Resident #2 revealed the following: - at 9:45 a.m., Staff G noted Resident #2 was disoriented and very . Staff G called 911 and Resident #2 was transported to a local hospital. - at 4:17 p.m. Resident #2 returned to the facility from the hospital via ambulance transportation. - [illegible] at 1:26 a.m., Staff H called Staff G stating that Resident #2 was outside and returned by police. Resident #2 states she went to smoke a cigarette and couldn't get into building. Staff H helped Resident # 2 to bed. - at 2:08 p.m., Power of Attorney (POA) visited Resident #2 and stated she "was not acting like her usual self" and requested Resident #2 be checked out. 911 was called and Resident #2 was sent to a local Hospital. - at 12:00 p.m., POA notified facility that Resident #2 "is still in hospital, is un communitive but doing better." - at 11:45 a.m., POA notified facility that "Resident #2 will be going to rehab to increase mobility and use. States Resident is talking and answering questions but still ". (photographic evidence	A 025		

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A 025	Continued From page 8 obtained) On a record review conducted of the facility sign out logs revealed there was no sign out for Resident #1 on and no sign out for Resident #2 on . (photographic evidence obtained) On a record review of an incident reported to the Agency for Healthcare Administration for Resident #20 revealed that Resident #20 eloped from the facility on . Resident #20 was last seen by Staff G and on camera at approximately 5:15 p.m. on . Staff G noticed Resident #20 missing around 7:30 p.m. on . Staff G searched the facility and local gas station for Resident #20. On at approximately 8:15 p.m. Staff G called 911. Resident #20 was returned to the facility on at 10:30 p.m. after Resident #20 was assessed at a local hospital. (photographic evidence obtained) On A record review of facility observation notes for the month of , regarding Resident #20 revealed Resident #20 eloped from the facility on . - at 11:19 p.m. Staff G called the Administrator and stated they have not seen Resident #20 since 7:28 p.m. The Administrator checked with receptionist via phone call to see if she saw Resident #20, receptionist stated no. Facility staff continued to search for Resident #20 in cars. 911 was called at 8:17 p.m. - at 4:00 p.m. "Resident taken to local hospital for severely , and elevated sugars." - at 5:43 p.m. [law enforcement] informed the Administrator that the Resident was found earlier today approximately miles away	A 025		

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A 025	Continued From page 9	A 025		

from facility. Resident #20 was taken to a local hospital due to appearing , .
- at 11:24 a.m. The Administrator meet with Resident #20. Administrator inquired about "his outing" on , Resident#20 did not remember why he left or where he was going. Resident #20 Stated did not know he had to sign out before leaving the facility. Resident #20 stated at around 9 p.m. he realized he didn't know where he was or how to get home. Resident #20 did not remember if he ate or slept. Resident # 20 only remembered cars whizzing past him and a female officer approached him and being taken to the hospital.
- at 11:39am The Administrator spoke with POA and stated that "the resident needs a secure facility and an immediate discharge for his well being and safety."

On a record review of the facility undated memory care policy revealed "[facility management company name] memory care is structured to meet the needs of 's and residents. The facility executive director will additionally need to be informed, verify and agree the facility can manage additional needs. Additional needs include, but are not limited to elopement risk, behavioral that is unacceptable in the general assisted living environment, diagnoses of 's or , a need of high levels of stimulation, or a need for a more structured routine." (photographic evidence obtained)

On In an attempted record review of the facility elopement drills and staff re-training were made, the elopement drills and additional staff training were requested but not provided.

On at 10:39 a.m. an interview

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A 025	Continued From page 10 conducted with the Regional Executive Director revealed the elopement drills were missing and could not be located. On at 2:59 p.m. an interview was conducted with the Administrator. The Administrator stated that there was no elopement retraining conducted after the recent elopements. On at 6:20 p.m. an interview was conducted with the Regional Director of Operations. The Regional Director of Operations stated the facility does not do elopement risk assessments. On at 8:30 p.m. an interview was conducted with the Regional Director of Operations. Regional Director of Operations stated that the staff should have answered the door alarms. Class I	A 025		
A 032 SS=F	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	A 032		

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A 032	Continued From page 11 admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the 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	A 032		

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A 032	Continued From page 12 contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (6)(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 record review and interview, the facility failed to ensure twice a year elopement drills were conducted and documented for all staff; and failed to provide staff with required elopement response training for one (Administrator) of four sampled staff. Furthermore, the lack of training, insufficient elopement response policy and the absence of facility initiated resident elopement risk assessments and intervention placed three (Resident #1, Resident #2 and Resident #20) of three sampled residents at significant risk for harm during and after recent elopements. Findings included: On an attempted record review of the facility's elopement drills was conducted and revealed that there was no evidence that the direct care staff participated in elopement drills. On a record review for the Administrator (hire date of) revealed no elopement response training on file. On at 8:27 a.m. an interview was conducted with Staff D. Staff D stated an unknown resident eloped from the facility two weeks prior. Staff D also stated there were	A 032		

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A 032	Continued From page 13 helicopters and police involved in the search. Additionally, Staff D said staff D had not participated in elopement drills. Staff D was hired on . On at 4:37 p.m. an interview was conducted with Staff G. Staff G stated Resident #1 left the facility and was gone 40 minutes before being found in a stranger's car by staff. Additionally, Staff G said staff G had not participated in elopement drills. Staff G was hired on . On at 10:39 a.m. an interview conducted with the Regional Executive Director revealed the elopement drills were missing and could not be located. On a review of Resident #1's record was conducted. Resident #1's record revealed that Resident #1 eloped from the facility on . On a review of Resident #2's record was conducted. Resident #2's record revealed that Resident #2 eloped from the facility on . On a review of Resident #20's record was conducted. Resident #20's record revealed that Resident #20 eloped from the facility on . On at 2:59 p.m. an interview was conducted with the Administrator. The Administrator stated that there was no additional elopement training conducted after the elopements of Resident #1, Resident #2 and Resident #20.	A 032		

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A 032	Continued From page 14	A 032		

On a record review was conducted of the facility's undated elopement policy and procedure. The facility's actions regarding their recent elopements revealed the facility failed to follow the following policies:

"Policy: This policy is to be followed when a resident has been identified or observed as a risk for ˬ and/or elopement. Every effort is made to prevent and track ˬ residents while maintaining the least restrictive environment for those who are at risk for elopement.
Elopement is defined when a resident leaves the facility property beyond the perimeter of the parking lot or further, without the facility knowledge, and who has not verbally informed the facility of their plans for returning.
Identify an at-risk resident at time of admission.
Inform responsible party at time of admission of the proper method for taking a resident out of the facility. Inform staff of an at risk resident upon admit and ensure proper intervention takes place.
Maintain a list of names and photographs near a central area.
Identify a reason that might cause a resident to . Most residents with often have a "reason" that could cause them to , such as going to work, visiting a relative across the street, going home, etc. Once you have this reason use it as your method for locating the resident.
Should an elopement occur, factors and the interventions and measures which were implemented to prevent this occurrence will be documented.
Immediately upon discovering that a resident is unaccounted for, a room-to-room search will be initiated. Every room in the building will be searched, including closets, bathroom, maintenance rooms, offices, kitchen, laundry

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A 032	Continued From page 15 room, and under beds and behind doors. If the resident is not found, the responsible party will be called to see if they have the resident and did not follow proper procedure to take the resident away from the facility. If the responsible party does not know the location of the resident, the local law enforcement will be notified. Copies of photos and demographics will be given to law enforcement personnel. Designated staff members will both canvass the local area on as well as a further in vehicles. This search will continue until the designee in charge determines that an appropriate amount of time has been spent attempting to locate the missing resident. Report the elopement in the resident's file." A review of the facility's undated elopement policy and procedure revealed that the policy failied to minimially address the following as required: The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities. 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. The continued care of all residents within the facility in the event of an elopement. (Photographic evidence obtained.) Class II	A 032		

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A 052	Continued From page 16	A 052		
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. (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	A 052		

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A 052	Continued From page 17 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 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.	A 052		

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A 052	Continued From page 18 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 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,	A 052		

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A 052	Continued From page 19 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 interview, the facility failed to ensure proper assistance with medication according to the proper steps for assisting with self-administration of medications for four Residents (Resident #5, Resident #9, Resident #10 and Resident #11) out of four sampled Residents. Findings included: An observation of the medication pass with Staff D (an unlicensed Medication Technician) for Resident #5, Resident #10, and Resident #11,	A 052		

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A 052	Continued From page 20 was conducted on between 8:01 a.m. to 8:20 a.m. Staff D assisted Residents #5, Resident #10 and Resident #11 with self-administration of medications. Staff D popped medications from original medication card at the medication cart while residents were not present. Furthermore, Staff D did not perform the proper hygiene required between the three medication passes observed. An observation of a medication pass with Staff E (an unlicensed Medication Technician) for Resident #9, was conducted on at 8:28 a.m. Staff E assisted Resident #9 with self-administration of medications. Staff E popped the medications from original medication card at the medication cart while the resident was not present. Furthermore, Staff E did not read the name and dose of medications to the resident. During an interview with the Regional Director of Operations, conducted on at 10:12 a.m., the Regional Director of Operations stated that it was the expectation for unlicensed Medication Technicians to pop the pills from the medication packs in front of the residents, read the name and dosage of the medications, and perform hygiene between medication passes. Class III	A 052		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible,	A 055		

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A 055	Continued From page 21 residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the	A 055		

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A 055	Continued From page 22	A 055		

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

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A 055	Continued From page 23 issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure that medications were kept locked in a cabinet, cart, or other receptacle at all times. Findings included: During an observation of the medication room, conducted on at 11:59 a.m., it was revealed that the door was wide open and there were no staff in or around the area. Inside the medication room, there was a small mini refrigerator that had three medications inside. There were also medications sitting on a counter inside of the medication room. (photographic evidence obtained) During an interview with the Regional Director of Operations, conducted on at 8:20 p.m., the Regional Director of Operations stated that medications should be kept locked at all times. Class III	A 055		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have	A 078		

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been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership.
1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of
2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable
(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

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A 078	Continued From page 25 provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain evidence of a negative ( ) examination annually from a health care provider and failed to obtain a one-time statement that the employee was free from communicable from a health care provider for one employee (Administrator) of four sampled employees. Findings included: An employee record review for the Administrator conducted on , revealed that the Administrator's employee records did not contain evidence that the employee had a negative examination annually. The Administrator's record did not contain a one-time statement that the employee was free from communicable from a health care provider. The Administrator was hired on .	A 078		

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A 078	Continued From page 26 During an interview with the Regional Executive Director, conducted on at 11:30 a.m., the Regional Executive Director stated the facility will continue to work on auditing employee records. Class III	A 078		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee ' s personnel record. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice	A 081		

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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 081	Continued From page 27 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 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,	A 081		

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	AL11966042	A. BUILDING: _____ B. WING _____	09/19/2025

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A 081	Continued From page 28 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: 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	A 081		

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A 081	Continued From page 29 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 interview, the facility failed to provide direct care staff with in-service trainings, which included training regarding activities of daily living and behavioral needs within thirty days of employment for one employee (Staff B) of four sampled employees. Findings included: A record review for Staff B, conducted on , revealed that Staff B's record did not contain evidence that Staff B obtained training regarding activities of daily living and behavioral needs. Staff B was hired on . During an interview with the Regional Executive Director, conducted on at 11:30 a.m., the Regional Executive Director stated the facility will continue to work on auditing employee records.	A 081		

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A 081	Continued From page 30 Class III	A 081		
A 152 SS=F	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and	A 152		

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A 152	Continued From page 31 personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to maintain sprinkler systems in good working order or provide building and mechanical system repairs that caused structural water damage to the ceiling and pipe leaks. The lack of maintenance caused a fire detection system to and placed all residents at risk for harm or exacerbation of health issues. Findings included: On between 12:15 PM to 1:00 PM observations of the facility were conducted. The Assisted Living Facility was a one-story facility and the following observations were revealed: " Hall in front of ceiling tile had brown staining on the ceiling tiles around sprinkler. " Hall from lobby to activity room had a paper , with minimal moisture on the floor and a closed sign on top of the , . The ceiling tiles above had multiple brown spots around the air conditioning (AC) vent. " Resident #1's room AC handler closet vent was covered with gray dust. " Light shade cover in front of was broken. " 300 hall was observed with many stained ceiling tiles and areas where chucks and buckets were observed on floor for water leaks. " Above door 307 the corner tile was stained brown approximately 10 inches next to a large stain approximately fifteen to twenty-inches stain behind the exit sign above .	A 152		

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A 152	Continued From page 32 " A large circular stain in the hallway by and approximately a 25-inch dark brown stain around light in the hallway by the nurse's station. " 300 halls had a large open area in the ceiling with exposed wires. " Circular area on the ceiling was observed approximately 8-inches with black bio-growth surrounding the hole resulting in a wet spot-on floor in the 300 hall by nursing station. " A wet floor sign with a wet towel under the sign was observed in the 300 hallway with open an access panel near nearby. " A second wet floor sign as observed along the 333 hallway. Two heavily dusty ceiling vents was observed by . On at 8:55 a.m. an observation of a fire panel at the front door showed a message that read "TOUBL WATERFLOW MECH ". (photographic evidence obtained) On at 10:39 a.m. an interview was conducted with the Regional Executive Director. The Regional Executive Director stated the Maintenance Director was gone. No other maintenance replacement or plan to hire was mentioned. On a record review was conducted of an undated Maintenance Supervisor job description. It revealed on page 2: "Maintain the building in good repair and keep free of hazards such as those caused by electrical, plumbing, heating and cooling systems, perform routine maintenance such as painting, repair work and various other routine maintenance tasks, remain on call for facility emergencies, inspect fire extinguishers every 30 days, maintain annual preventative maintenance and be familiar with fire	A 152		

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A 152	Continued From page 33 standard precautions, fire drill and evacuation procedures." On a record review was conducted of a fire inspection report dated revealed that due to violations, the facility is currently on Firewatch. The violations included fire alarm and sprinkler system failure. (photographic evidence obtained) On at 1:22 p.m. a phone interview was conducted with a local emergency management agency representative who said the last facility emergency management plan approval was dated and the facility had trouble with fire plan approval in the past which caused delays to emergency management plan approval. On at 1:39 p.m. a phone interview was conducted with a high-ranking official at a local fire rescue agency. The official stated if the fire alarm was not working and was in trouble mode then the alarm would not contact a fire department. The official confirmed a fire watch was when someone from the facility was monitoring every hour and acted as a mobile smoke detector, which required completion of the Firewatch check form every hour until cleared by the representative of the local fire rescue agency. Additionally, the official said the facility was required to do their due diligence and were responsible until the department assessed and cleared the fire watch. On at 4:24 p.m. an interview was conducted with the Administrator. The Administrator reported there were valves for the water system that needed to be replaced that caused leaks through ceiling tiles, and the	A 152		

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A 152	Continued From page 34 sprinklers caused the fire detection system to reset and go into trouble mode on Tuesday, . On Tuesday, , the sprinklers caused too much pressure for the pipe in the 300 hallway and caused a leak that , resident rooms. Furthermore, the Administrator said they had an estimate for a roof repair dated . The Administrator said they were under the impression that they could stop the fire watch when the sprinklers were repaired but hoped it would be cleared on Monday, . On at 2:00 p.m. a phone interview was conducted with a local fire agency representative who said the facility was on fire watch and they needed to continue until it was determined by their agency that the fire detection and sprinkler systems were in working order. The local fire agency representative said the facility needed to get any leaks taken care of to prevent risk to residents by the need to turn off the water that would feed sprinklers in a fire. On at 6:02 p.m. an interview was conducted with Resident #12. Resident #12 stated there have been several leaks since . On at 6:02 p.m. an interview was conducted with Resident #13. Resident #13 stated there were leaks for the last two weeks that continued to that day. On at 12:32 p.m. an interview was conducted with Staff D. Staff D stated there were areas in the wing that had leaked since and there was a pipe that burst on that flooded the 300-resident hallway. Additionally, surveyors had to point out that an approximate six inch circle with one inch hole in	A 152		

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A 152	Continued From page 35 the center on the ceiling had dripped a spot of water on the floor of the resident hallway near the nurse's station and asked Staff D to get a wet floor sign. Staff D offered to show a video from of leak from 300 hall on a cellphone. On at 12:36 p.m. an observation was conducted of the video from the leak that occurred on in the 300 halls on her cellphone which showed water pouring at a rapid pace from the ceiling. (video evidence obtained) On at 12:38 p.m. an interview was conducted with Resident #22. Resident #22 stated the hallway had flooded on but it had been cleaned up. On at 12:58 p.m. an interview was conducted with Staff K. Staff K stated there was a resident room with a leak, and they described the location in the 300 hallway for Resident #21's room. On at 12:52 p.m. an observation was conducted of Resident #21's room. Resident #21's room appeared to have a long strip of ceiling paint and ceiling stucco that was hanging down in the center of the room. Resident #21 stated the leak in the room occurred during a storm on and that the facility had not repaired it. Additionally, Resident #21 stated they had moved their bed closer to the wall to avoid the area, and had a bucket with plastic and supplies in case of another leak that would happen when it rained. (photo evidence obtained.) On a record review was conducted for a roofing repair proposal dated with an attached email dated from the	A 152		

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A 152	Continued From page 36 roof company representative who would schedule the repair with a 50% deposit paid. On a record review was conducted of fire watch form dated . The fire watch form revealed that the facility started fire watch on at noon through at 4 p.m.. No others observations were documented on the form. On at 1:21 p.m. an interview was conducted with the Administrator. The Administrator stated the Fire watch log was stopped on pm at 4:00 p.m. because the Administrator thought since the sprinkler was fixed and the facility didn't have to do the fire watch log anymore. Class II	A 152		
A 165 SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means:	A 165		

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A 165	Continued From page 37 (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415.	A 165		

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A 165	Continued From page 38 (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to file an Adverse Incident Report (AIR) to the Agency for Healthcare Administration (AHCA) within one business day for Three Resident's	A 165		

Agency for Health Care Administration

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A 165	Continued From page 39 (Resident #1, Resident #2, and Resident #16) out of Three sampled Resident's. Findings included: A review of Resident #1's record conducted on revealed that Resident #1 eloped from the facility on . There was no evidence found that facility submitted an AIR to AHCA. A review of Resident #2's record conducted on revealed that Resident #2 eloped from the facility on . There was no evidence found that facility submitted an AIR to AHCA. A review of Resident #16's record conducted on revealed that Resident #16 was admitted to the hospital with a diagnosis of a after a on . There was no evidence found that facility submitted an AIR to AHCA. During an interview with the Administrator conducted on at 11:00am, the Administrator stated that no AIR's were submitted to AHCA for incidents with with or elopements. Class III	A 165		

Agency for Health Care Administration

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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 record review and interview, the facility failed to ensure employees were added to Agency for Healthcare Administration (AHCA) Background Screening Roster within five business days of hire date, for one staff (Staff F) of seven sampled staff. Findings included: A review of Staff F's employee record conducted on revealed Staff F had a hire date of . A review of the facility's AHCA background screening roster conducted on revealed Staff F was not listed on the facility's AHCA Background Screening Roster. In an interview with the Regional Executive Director conducted on at 11:28 a.m., the Regional Executive Director agreed the facility	ZZ814		

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ZZ814	Continued From page 2 has five days to add staff members to the AHCA Background Screening Roster. (Photographic evidence obtained) Unclassified	ZZ814		
ZZ816	408.809(2) 435.05(2) 59A-35.090(2d-3b) Background Screening-Compliance Attestation 408.809 Background screening; prohibited offenses.- (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's ␣ , to the Federal Bureau of Investigation for a national criminal history record check unless the person's ␣ , are enrolled in the Federal Bureau of Investigation's national retained print notification program. If the ␣ , of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit ␣ , electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the ␣ , to the Federal Bureau of Investigation for a national criminal history record check. The ␣ , shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print notification program when	ZZ816		

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ZZ816	Continued From page 3	ZZ816		

the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person , , . The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that:
(a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section;
(b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and
(c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency.

435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers:
(2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if for any of the disqualifying offenses while employed by the employer.

59A-35.090 Background Screening.
(d) Attestation of Compliance with Background

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ZZ816	Continued From page 4 Screening Requirements, AHCA Form 3100-0008, , herein incorporated by reference, must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if for any disqualifying offense. The Attestation of Compliance is available at https://www.flrules.org/Gateway/reference.asp?No=Ref-17724, and available from the Agency for Health Care Administration's website at: https://ahca.myflorida.com/health-care-policy-and-oversight/bureau-of-central-services/background-screening/additional-information/regulations. (e) An administrator or chief financial officer must be screened and qualified prior to , , to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, correspondence will be sent to the individual being screened requesting the report and court disposition information. Pursuant to Section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with Section 435.06(3), F.S.	ZZ816		

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ZZ816	Continued From page 5 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure employees signed an affidavit or attestation of compliance with background screenings for one employee (Staff C) of four sampled employees. Findings included: An employee record review for Staff C, conducted on , revealed that Staff C's employee record did not contain an affidavit or attestation of compliance signed by the employee. During an interview with the Regional Executive Director, conducted on at 11:30 a.m., the Regional Executive Director stated the facility will continue to work on auditing employee records. Unclassified	ZZ816		
ZZ830	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	ZZ830		

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ZZ830	Continued From page 6 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 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	ZZ830		

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ZZ830	Continued From page 7 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 approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to submit their Comprehensive Emergency Management plan (CEMP) annually. Findings included: A facility record review conducted on revealed the facility's CEMP had not been submitted and the last local organization	ZZ830		

Agency for Health Care Administration

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ZZ830	Continued From page 8 correspondence was dated , that said the plan was approved. In an interview with a local emergency management agency representative conducted on at 1:22 p.m., the agency representative stated the facility has not submitted a new CEMP. In an interview conducted with the Administrator on at 10:45 a.m., the Administrator stated they are working with the local emergency management office and agreed they have not submitted their CEMP. Unclassified	ZZ830		