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
	AL11942934	A. BUILDING: _____ B. WING _____	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT POMPANO BEACH LLC	295 SW 4TH AVENUE POMPANO BEACH, FL 33060

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A 000	Initial Comments An unannounced Relicensure, Extended Congregate Care (ECC), Limited Mental Heath (LMH) and Generator Monitoring survey was conducted on [redacted] at The Residence At Pompano Beach LLC. The facility had deficiencies related to the Relicensure, Extended Congregate Care (ECC) and Limited Mental Heath (LMH) at the time of the survey.	A 000		
A 010	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual	A 010		

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

(2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of

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

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A 010	Continued From page 3 plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their	A 010		

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A 010	Continued From page 4 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 record review, interview and observations, it was determined that, the facility failed to ensure that a resident was reassessed and finding updated on a new Resident Health Assessment form (AHCA form 1823) upon the resident exhibiting significant health changes and receiving additional nursing services, for 1 of 2 sampled resident records reviewed (Resident #12). The findings included: During an interview with the Director of Nursing (DON) on /2025at 1:00 PM, it was revealed that Resident #12 is receiving hospice services. She also provided a list of hospice residents, in which Resident #12 was listed. Review of Resident #12's file revealed she was admitted to the facility on and enrolled into hospice services on . Review of Resident #12's health assessment (AHCA form 1823) dated revealed the following diagnosis; left , , , protein calorie , Sarcopenia, , , Gait instability, , , .The resident status noted as alert and oriented to person, place, and time with periods of forgetfulness, and the resident's nursing services noted as Assistance with self-administration of medication. The resident required assistance with her ADLs	A 010		

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A 010	Continued From page 5 (Activities of Daily Living). During a further interview with the DON on , she was questioned if the resident had received a new assessment due to the significant health changes and enrollment into hospice services. She stated Resident#12's most recent assessment was and that she had not been reassessed. During an interview conducted on at 4:15 PM with the Administrator, she stated that Resident #12 was under hospice and was actively receiving hospice services. At this time, she was informed that Resident #12's health assessment did not reflect the resident was receiving hospice services. Class III	A 010		
A 030	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the 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	A 030		

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

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sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside.

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

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A 030	Continued From page 8 visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , 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	A 030		

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A 030	Continued From page 9 termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and 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	A 030		

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A 030	Continued From page 10 State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or 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	A 030		

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A 030	Continued From page 11 management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on interview and record review, it was determined, the facility failed to implement and follow an effective grievance procedure that demonstrated a system for receipt and resolution of all grievances of residents and/or their representatives. This was evidenced by the facility's failure to maintain documentation of resolutions to resident grievances. The findings included: A review of the facility's policy for grievances titled, "Policy and Procedures for Resident Complaint/Grievance/ The Right to Report" [no effective date] revealed the following: 1) The resident's monthly meeting is used as a medium for residents to express themselves in terms of complaints or grievances related to any issue that affects them in their living environment. 2) The provider or staff who has the responsibility of initiating the meetings , documents grievances and complaints voiced by the residents as well as interventions done by appropriate staff to each complaint for satisfactory solution. 3) On an ongoing basis residents are allowed to voice problems to the provider or staff in charge, at any given time on individual basis. The problems shall be also documented on a Complaint Log as well as follow-up actions taken by the provider to resolve such problems. 4) The provider shall ascertain feedback from the residents in order to determine if interventions made resolution for satisfactory to resident(s)	A 030		

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A 030	Continued From page 12 who made the complaint. During an interview conducted with the Administrator on at 10:17 AM, she stated that she was responsible for documenting the receipt and resolution of resident grievances. During an interview conducted with Resident #35 on at 1:25 PM, he stated that he was concerned that the facility had not been having activities for the past few weeks. Additionally, he stated that there was daily arguments between residents at lunch and dinner times and the Administrator was aware. Resident #35 stated his complaints go unresolved by the Administrator and he was tired of it. During an interview conducted with Resident #36 on at 3:29 PM, she stated that the facility had no activities and that's why the residents were arguing everyday. Additionally, she stated that complaining to the Administrator was useless because nothing got done. During an interview conducted with Resident #37 on at 3:36 PM, he stated that the facility did not provide enough activities for the residents to participate in. He stated that the facility only plays bingo with the residents. Additionally, he stated that he had mentioned his concerns to the Administrator before. During an interview conducted with Resident #38 on at 3:47 PM, she stated that the facility did not have any activities besides bingo and there has been no television in the common areas for the past two weeks. She further stated the Administrator was aware of the lack of activities and nothing had been done about it.	A 030		

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A 030	Continued From page 13 A review of the facility's grievance documentation (binder) revealed the following information: Grievances from , of 2025 to current were provided, the following concerns were noted; a) There was no documentation of any complaints regarding activities. b) There was no documentation of any of the resident's who expressed concerns in the grievance binder at all. During an interview with the Administrator on at 4:45 PM, she stated that the facility did address the resident's concerns about activities. When documentation was requested, she could not provide any. At this time, the Administrator acknowledged the finidngs and stated she would address the receipt and resolution of all grievances to ensure the resident's rights were honored. Class III	A 030		
A 052	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	A 052		

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A 052	Continued From page 14 that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into 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.	A 052		

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A 052	Continued From page 15 (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH 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	A 052		

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A 052	Continued From page 16 advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving 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	A 052		

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A 052	Continued From page 17 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, it was determined that, the facility failed to ensure staff accurately assisted with self-administration of prescribed medication, by failing to follow the method ordered by the physician 1 of 2 sampled residents (Resident #14). The findings included: During medication pass on at 1:00 PM, this surveyor observed Staff # C (MedTech), assisting with self-administration of medication. This surveyor observed Staff # C placed three medications in a cup and handed them to the resident(Resident #14) with a cup of water. The resident swallowed the medications, in which one of the medications were tab 4MG . Review of the medication observation record (MOR) document indicated the following medication should be administered (under the). Tab 4 MG ODT (orally disintegrating tablet) Take 1 tablet every 8 hours as needed for or .	A 052		

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A 052	Continued From page 18 During an interview conducted on at 1:13 AM with Staff C, she stated that the resident had always taken her medications with water. During an interview conducted on at 1:45 PM with the Administrator, she stated that the medication would not have the same effect because the physician ordered method was not followed by the Staff # C. The Administrator acknowledged the findings. Class III	A 052		
A 078	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a 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	A 078		

Agency for Health Care Administration

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A 078	Continued From page 19 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with 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,	A 078		

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A 078	Continued From page 20 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, it was determined that, the facility failed to ensure staff had documented evidence of Communicable Status and negative ( ) examination for 4 of 4 sampled Staff (Staff A, D, E and F). The findings included: 1) Review of the personnel file for Staff A (Administrator) with a hire date of revealed Staff A did not have documented evidence of Communicable Status. Further review revealed her file did not have documentation of annual negative examination status and thereafter for the years 2021, 2022, 2023, 2024 and 2025 as required by statutory regulation (freedom from must be documented annually). 2) Review of the personnel file for Staff D (Memory Care, caregiver) with a hire date of revealed Staff D did not have documented evidence of Communicable Status. Further review revealed her file did not have documentation of annual negative examination status and thereafter for the years 2023, 2024 and 2025 as required by statutory regulation (freedom from must be documented annually). 3) Review of the personnel file for Staff E (Medication Technician) with a hire date of revealed Staff E did not have documented evidence of Communicable Status. Further review revealed her file did not have documentation of annual negative	A 078		

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A 078	Continued From page 21 examination status and thereafter for the years 2022, 2023, 2024 and 2025 as required by statutory regulations (freedom from must be documented annually). 4) Review of the personnel file for Staff F (caregiver) with a hire date of revealed Staff F did not have documented evidence of Communicable Status within 30 days of hire. Further review revealed no documentation of annual negative examination in her file. During an interview on at approximately 1:00 PM, team of surveyors met with the Administrator and she was informed of the findings. At this time, she acknowledged the findings. No additional documentation was provided. Class III	A 078		
A 081	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee ' s personnel record.	A 081		

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A 081	Continued From page 22 (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted 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	A 081		

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A 081	Continued From page 23	A 081		

the facility administrator, the preservice orientation must cover:
1. Resident's rights; and,
2. The facility's license type and services offered by the facility.
(3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff:
(a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement.
(b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects:
1. Reporting adverse incidents.
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

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A 081	Continued From page 24 prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that, the facility failed to ensure all staff had completed the required in-service training within 30 days of hire, for 1 of 4 sampled Staff (Staff F).	A 081		

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A 081	Continued From page 25 The findings include: Review of the personnel file for Staff F (caregiver) with a hire date of revealed the employee had not completed the following required in-service trainings; Preservice Orientation, Reporting Major Incidents, Reporting Adverse Incidents, Facility Emergency Procedures, Incident Reporting Training and Elopement training in her file. During an interview on at approximately 1:00 PM the Administrator was informed of the findings. No additional documentation was provided. Class III	A 081		
A 090	59A-36.011(11) FAC Training - (11) TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding . (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was	A 090		

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A 090	Continued From page 26 determined that, the facility failed to ensure direct care staff had training for ( ) for 1 of 4 sample staff (Staff F). The findings included: Review of the personnel file for Staff F (caregiver) with a hire date of revealed Staff F did not have documented evidence of training for in her file. During an interview on at approximately 1:00 PM, team of surveyors met with the Administrator and she was informed of the findings. At this time, she acknowledged the findings. No additional documentation was provided. Class III	A 090		
A 092	59A-36.012(1) FAC Food Service - General Responsibilities (1) GENERAL RESPONSIBILITIES. When food service is provided by the facility, the administrator, or an individual designated in writing by the administrator, must be responsible for total food services and the day-to-day supervision of food services staff. In addition, the following requirements apply: (a) If the designee is an individual who has not completed an approved assisted living facility core training course, such individual must complete the food and nutrition services module of the core training course before assuming responsibility for the facility's food service. The designee is not subject to the 1 hour in-service training in safe food handling practices.	A 092		

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A 092	Continued From page 27 (b) If the designee is a certified food manager, certified dietary manager, registered or licensed dietitian, dietetic registered technician, or health department sanitarian, the designee is exempt from the requirement to complete the food and nutrition services module of the core training course before assuming responsibility for the facility's food service as required in paragraph (1)(a) of this rule. (c) An administrator or designee must perform his or her duties in a safe and sanitary manner. (d) An administrator or designee must provide regular meals that meet the nutritional needs of residents, and therapeutic diets as ordered by the resident's health care provider for residents who require special diets. (e) An administrator or designee must comply with the food service continuing education requirements specified in rule 59A-36.011, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and interview, it was determined that, the facility failed to ensure general responsibility for the day-to-day supervision of food services, including knowledge of food being served and prepared in a safe/sanitary manner for residents that reside in the Memory Care Unit (MCU). The findings included: A review of the facility's Proper Food Handling, Food Safety, and Sanitation documentation undated, documented as follows: Policy: It is the policy of the Assisted Living Facility to practice in a manner that prevents the spread of foodborne illness by adhering to and following standard safe food practices.	A 092		

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A 092	Continued From page 28 Procedure: It involves recognizing the common problem Clean means good housekeeping and thorough sanitation of equipment Cooked means bring food to an internal temperature. Cooked foods must then be held at a high enough temperature to keep the food safe (135 Fahrenheit or greater). Suitable utensils, such as deli paper, dispensing equipment shall be used. Temperature Hot Holding: Reheating for hot holding: potential hazardous food that is cooked, cooled and reheated for hot holding shall be reheated so that all parts of the food reach a temperature of at least 165 Fahrenheit degrees for 15 seconds within two hours. Food and Utensil Storage and Handling Thermometers: A thermocouple or metal stem thermometer shall be provided to check hot and food items. Food temperature measuring devices shall be accurate. Cross-Contamination: Food shall be protected from cross-contamination by separating from ready-to-eat foods during storage, preparation, holding and display. Equipment and utensils must be thoroughly cleaned and sanitized. Memory Care dining area is located in front of the Memory Care Director's office, further observation revealed that the office has a clear glass window with direct view to the dining area.	A 092		

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A 092	Continued From page 29 Memory Care unit meals are carried out in a hot box from the main kitchen in the Assisted Living for all the residents that reside at the memory care. During a tour conducted on between 12:00 PM and 2:30 PM, the surveyors observed the following concerns in the MCU dining area: 1.) During a meal pass an observation was made during lunch between 12:15 PM and 12:45 PM. Lunch was observed inside a metal hot box that contained plated food that was uncovered, further observation revealed some of the plates were Styrofoam and some of the plates were plastic that had a side salad, and meat taco on a soft flower tortilla (photographic evidence was obtained). Observations of the hot box revealed: An electric cord that was wrapped on the side of the hot box. Thermometer and food temperate dial knob located in front of the hot box. Small holes on the metal covering, metal covering was dented, metal covering had scuff marks in Front of the hot box. One (1) door hinge was hung at the right bottom of the hot box. A black rubber strip was observed to be ripped on the side of the openings (front of the hot box). (photographic evidence was obtained) Furthermore, observations revealed that inside of the hot box had three shelves (metal racks) and approximately 4 metal dish racks to hold additional plates (on the top rack). Metal shelves/racks and dish racks were greasy and grimy. Bottom base of the hot box had accumulated food debris and dirty (photographic	A 092		

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A 092	Continued From page 30 evidence was obtained). 2.) Observations of the three-layer utility cart (plastic)that was used for placing fruit cups, yogurt, and extra supplies like straws, cups, napkins and plastic juice dispenser revealed: the utility cart had a broken push handle with exposed pointy sharp ends sticking out, cart was dirty, cart had food spills/debris and plastic juice dispenser was missing the lid and spout was broken (photographic evidence was obtained). During an interview on at approximately 12:35 PM with Staff G (Memory Care Director) she was asked to join the team of surveyors during the meal pass to observe the conditions mentioned above. At this time, she stated she was not aware of it. During an interview on at approximately 2:55 PM team of surveyors met with the Administrator in the main lobby (common area) and kitchen staff (that was pushing the hot hox to the main kitchen). At this time, she was shown the hot box and its condition, she stated she was aware of the hot box missing the door. She acknowledged the findings. Class III	A 092		
A 120	429.17(3) .275(1); 59A-36.013(1) FAC Fiscal - Financial Stability 429.17 (3) In addition to the requirements of part II of chapter 408, each facility must report to the agency any adverse court action concerning the facility's financial viability, within 7 days after its occurrence. The agency shall have access to	A 120		

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A 120	Continued From page 31 books, records, and any other financial documents maintained by the facility to the extent necessary to determine the facility's financial stability. 429.275 (1) The administrator or owner of a facility shall maintain accurate business records that identify, summarize, and classify funds received and expenses disbursed and shall use written accounting procedures and a recognized accounting system. 59A-36.013 Fiscal Standards. (1) FINANCIAL STABILITY. The facility must be administered on a sound financial basis in order to ensure adequate resources to meet resident needs pursuant to the requirements of chapter 408, part II, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, it was determined that, the facility failed to maintain financial stability. The facility failed to ensure timely payments of utilities (water) that are necessary for the care and services provided to residents that reside in the Assisted Living and Memory Care Unit. The findings included: An observation during a tour conducted on between 8:30 AM and 3:00 PM, team of surveyors toured the resident's room in Section One and observed that when running the water in their shower and bathroom sink, there was water trickling. Further into the tour in Section One team of surveyors observed that the water was no longer	A 120		

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A 120	Continued From page 32 tricking and water was shut off completely. During an interview on at approximately 10:20 AM with Staff G (Memory Care Director) immediately she was informed of the findings. At this time, Staff G toured Section One of the MCU with the team of surveyors and acknowledged the findings. She stated she was not aware there was no running water also confirmed that the staff (first shift) in the Memory Care Unit had not communicated to her that there was no running water. At 10:24 AM Staff G stated she was going to call the Administrator and let her know Section One did not have running water. After following up with the Administrator, Staff G stated that the Administrator contacted the local city to further investigate the matter. However, Staff G and the Administrator never stated why the water was currently not running in the Memory Care Unit in Section One during the tour. During a confidential conference call on at approximately 10:55 AM with the local city water officials, it was revealed that the facility had past due invoices and from time to time the water pressure was lowered as a reminder of the outstanding past due balances. Additionally, they stated the facility had four accounts with the local City Water Department (more than one water meter) therefore the facility had multiple outstanding amounts that were past due as of . During an interview on at approximately 10:25 AM with the Administrator, she was informed of the findings. At this time, she was asked to provide proof of the last three (3) water bill payments. The Administrator stated she	A 120		

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A 120	Continued From page 33 does not pay for the facility's bills directly. She further stated all accounts payable are handled through the corporate office in New York, but she does receive copies of the facility's bills. The Administrator then confirmed that the facility water bills were past due. During an interview on at approximately 12:20 PM, a conference call was conducted with the Administrator, she was informed and reminded that the facility must be administered on a sound financial basis, which allows the timely and accurate payment of utilities designed to avoid interruption of utilities/services vital to the health, safety and welfare of the residents. Due to the intervention of the Agency, the Administrator paid past due balance on the date of the survey. She provided proof of paid invoices (manual checks paid to the local city) as followed: a) Payment of $5,694.18 b) Payment of $ 18.35 c) Payment of $ 7,411.25 1) Billing Date - Facility paid the total due of $5,694.18 Previous Balance: $4,597.88 Balance forward $2,739.57 Current charges $2,954.61 Total Due: $5,694.18 Current charges due Shutoff Date Further review of the facility utility bills (water) revealed an invoice for services rendered for documented as follows: 2) Billing Date Previous Balance: $11,970.76 Balance forward $1,858.31	A 120		

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A 120	Continued From page 34 Current charges $2,739.57 Total Due: $4,597.88 Current charges due Shutoff Date Further, review revealed services rendered for the month of , had 3 invoices documented as follows: 3) (a) Billing Date Previous Balance: $6,739.39 Balance forward $0.0 Current charges $7,527.71 Total Due: $7,527.71 Current charges due (b) Billing Date Previous Balance: $126.00 Balance forward $126.00 Current charges $18.35 Total Due: $144.35 Current charges due Shutoff Date (c)Billing Date Previous Balance: $10,112.45 Balance forward $10,112.45 Current charges $1,858.31 Total Due: $11,970.76 Current charges due Shutoff Date During an interview with the Administrator on at approximately 5:00 PM, a team of surveyors met with the Administrator, she acknowledged the findings and stated she understood the impact of financial instability on the safety and welfare of the residents.	A 120		

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A 120	Continued From page 35 Class III	A 120		
A 152	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 personal laundry services for residents who	A 152		

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A 152	Continued From page 36 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 record review, observation and interview, the facility failed to provide a safe, clean and decent living environment free of safety hazards for residents that reside at the facility (Assisted Living and Memory Care Unit). The findings included: A review of the facility's Pest Control Policy undated, documented as follows: Pest can pose significant problems to people, to property and the environment. Pest management objectives Maintain a safe and sustainable facility environment. Prevent pest from spreading beyond community property. Enhance the quality of life for residents. Process The Administrator will oversee the implementation of this policy. The Administrator is responsible for following up with pesticide applications-methods, materials, timing and location. The Administrator will assure that all pest control contractor's recommendations on maintenance and sanitation being carried out where feasible. A) Review of the Facility's annual Group Care inspection report from DOH dated revealed that, the facility had an unsatisfactory re-inspection of which resulted in a violation. The report was documented as follows: Violation #27, Infestation /Present	A 152		

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A 152	Continued From page 37 Observed and alive roaches in , , , 222, 233, 315. Unsatisfactory. Provide pest control service. Clean and area. During a tour conducted on and between 8:30 AM and 3:00 PM, the surveyors observed the following physical plant concerns. B) Memory Care Unit (MCU) common areas: 1. Memory Care Unit main entrance, first set of doors located in wing B,C,D revealed the door was unlocked. Further observation revealed keypad that is used with a secure entry code was not working, metal bar that is used for pushing the door had missing pieces and the door handle was broken. Therefore, leaving the MCU doors unlocked and unsecured for residents of whose rooms (through 319) are located in Section One (1) of the MCU. During an interview on at approximately 10:00 AM with Staff J (Medication Technician) he was asked how long the door has been broken (unable to lock) and he stated he was not aware of it. During an interview on at approximately 10:15 AM with Staff G (Memory Care Director) she was asked how long the door has been broken (unable to lock) and she stated since last week (unable to provide date). At this time, she was asked if the administrator was aware of it and she stated yes. Staff G stated that residents that reside in Section One (1) do not return to their rooms until it's bedtime to prevent residents from leaving the secure unit.	A 152		

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A 152	Continued From page 38 During an interview on at approximately 11:50 AM the Administrator confirmed she was aware of the door being broken. At this time, she was giving an opportunity to provide documentation for the MCU door to be repair. No additional documentation was provided during survey. 2.Observation was made of the dining / activity room that approximately 10 chairs for resident use, were stained with visible discoloration, dirt, grime and food spills. Further observation revealed approximately 3 windows (around the memory care unit) had missing and/or broken slat blinds (horizontal white slats) photographic evidence was obtained. 3.Observation was made of the dining room wall near the nurse's station, the wall had big indentations, unfinished construction work, scuff marks below the windowsill. (photographic evidence was obtained). 4.Observation was made of the wall near the fire alarm device: unfinished construction work was observed (photographic evidence was obtained). 5.Observation was made of the resident's common area where they gather to watch Television (TV), the TV stand had a broken drawer. Further observation revealed TV stand had grime and dust on the top. Corner wall near TV area had unfinished construction work. (Photographic evidence was obtained). 6. Approximately 3 sofas in the common area had a very strong smell, residents were observed sitting and laying on them. Further observation revealed dirt, grime and food spills on the sofas (Photographic evidence was obtained).	A 152		

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A 152	Continued From page 39 7.Observation was made of the memory care enclosed parking lot where facility staff gather residents for walking and other activities revealed: approximately 4 broken chairs, plastic bench that had dirt, grime and food spills. Parking lot entrance floor near the door was stained and grimy, approximately 5 empty flowerpots scattered, loose wood on the floor, area was unkept and untidy (Photographic evidence was obtained). 8.Observation of the corner wall where the memory care stores chair scale revealed unfinished paint on the walls, scuffed marks and missing baseboard. (Photographic evidence was obtained). 9. Observation of revealed: ceiling seam where it connects to the wall had what appeared to be water stains dripping from the ceiling onto the wall. Furthermore, revealed separation of the ceiling and the wall near the window and surrounding area (Photographic evidence was obtained). C) Assisted Living: 1.Observation of the common area /Lobby (main entrance) had unfinished floor work (no tiles) approximate square area of 25 by 25 (25" ft. x 25" ft.) 2.Observation of the library near the MCU: had exposed plumbing, electrical wires, unfinished walls with metal frame exposed and unfinished floor tile. Ceiling area near light fixture and air conditioning vent had a small hole and surrounded area that had large stain (brownish discoloration) photographic evidence was	A 152		

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A 152	Continued From page 40 obtained. 3. Wing B,C,D hallway: double metal doors with exit to the courtyard had peeling paint and scuff marks (photographic evidence was obtained). During an interview with the Administrator on at approximately 5:00 PM, a team of surveyors met with the Administrator. She was informed of the physical plant concerns. The Administrator acknowledged the findings. Class III	A 152		
A 161	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff	A 161		

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A 161	Continued From page 41 training and continuing education required by Rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section 429.174, F.S., and Rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity ⌄ to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by Rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to maintain personnel records that contain documentation of background screening for 1 of 4 sample staff (Staff F). The findings included: Review of the personnel file for Staff F (caregiver)	A 161		

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	AL11942934	A. BUILDING: _____ B. WING _____	08/19/2025

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A 161	Continued From page 42 with a hire date of revealed Staff F did not have documentation of a background screening in her file. During an interview on at approximately 2:00 PM, the Administrator was informed of the findings. She acknowledged the documentation was missing from her file. Class III	A 161		
AE210	59A-36.011(8) FAC ECC - Training (8) EXTENDED CONGREGATE CARE (ECC) TRAINING. (a) The administrator and ECC supervisor, if different from the administrator, must complete core training and 4 hours of initial training in extended congregate care prior to the facility receiving its ECC license or within 3 months of beginning employment in a currently licensed ECC facility as an administrator or ECC supervisor. Successful completion of the assisted living facility core training shall be a prerequisite for this training. ECC supervisors who attended the assisted living facility core training prior to , , , shall not be required to take the assisted living facility core training competency test. (b) The administrator and the ECC supervisor, if different from the administrator, must complete a minimum of 4 hours of continuing education every two years in topics relating to the physical, , , , or social needs of frail elderly and persons, or persons with 's or related . (c) All direct care staff providing care to residents in an ECC program must complete at least 2 hours of in-service training, provided by the	AE210		

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AE210	Continued From page 43 facility administrator or ECC supervisor, within 6 months of beginning employment in the facility. The training must address ECC concepts and requirements, including statutory and rule requirements, and the delivery of personal care and supportive services in an ECC facility. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain the required trainings for the provision of the Extended Congregate Care (ECC) license. This was evidenced by the facility's failure to ensure that 48 of 50 direct care staff (Staff B- S, Staff U-LL) completed at least 2 hours of mandatory Extended Congregate Care training. The findings included: During an interview conducted with the Administrator on at 9:57 AM, she stated the facility had a license to provide extended congregate care (ECC). Additionally, she stated that Staff L (Director of Nursing). At this time, the documentation for the ECC licensure was requested. A review of the facility's ECC documentation (binder with trainings and records) revealed the following: 1) The Administrator had a hire date of . There was documentation of a 4-hour extended congregate care training that was completed on . 2) Staff L had a hire date of . There was documentation of a 4-hour extended congregate care training that was completed on .	AE210		

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AE210	Continued From page 44 There was no other documentation that the other 48 members of direct care staff had completed at least 2 hours of mandatory Extended Congregate Care training. During an interview conducted with the Administrator on at 2:37 PM, she stated that only she and Staff L (Director of Nursing) completed the training for the ECC licensure. Additionally, she stated that she was aware that the direct care staff (Staff B- S, Staff U-LL)) had not completed at least 2 hours of mandatory Extended Congregate Care training. Class III	AE210		
AL243	429.075(1) FS; 59A-36.011(9) FAC LMH - Training 429.075 (1) To obtain a limited mental health license, a facility must hold a standard license as an assisted living facility, must not have any current uncorrected violations, and must ensure that, within 6 months after receiving a limited mental health license, the facility administrator and the staff of the facility who are in direct contact with mental health residents must complete training of no less than 6 hours related to their duties. This designation may be made at the time of initial licensure or relicensure or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with this part, part II of chapter 408, and applicable rules. This training must be provided by or approved by the Department of Children and Families.	AL243		

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AL243	Continued From page 45 59A-36.011 (9) LIMITED MENTAL HEALTH TRAINING. (a) Pursuant to section 429.075, F.S., the administrator, managers and staff, who have direct contact with mental health residents in a licensed limited mental health facility, must receive the following training: 1. A minimum of 6 hours of specialized training in working with individuals with mental health diagnoses. a. The training must be provided or approved by the Department of Children and Families and must be taken within 6 months of the facility's receiving a limited mental health license or within 6 months of employment in a limited mental health facility. b. Training received under this subparagraph may count once for 6 of the 12 hours of continuing education required for administrators and managers pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 2. A minimum of 3 hours of continuing education, which may be provided by the ALF administrator, online, or through distance learning, biennially thereafter in subjects dealing with one or more of the following topics: a. Mental health diagnoses; and, b. Mental health treatment such as: (I) Mental health needs, services, behaviors and appropriate interventions; (II) Resident progress in achieving treatment goals; (III) How to recognize changes in the resident's status or condition that may affect other services received or may require intervention; and, ( ) Crisis services and the procedures. 3. For administrators and managers, the continuing education requirement under this	AL243		

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AL243	Continued From page 46 subsection will satisfy 3 of the 12 hours of continuing education required biennially pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 4. Administrators, managers and direct contact staff affected by the continuing education requirement under this subsection shall have up to 6 months after the effective date of this rule to meet the training requirement. (b) Administrators, managers and staff do not have to repeat the initial training should they change employers provided they present a copy of their training certificate to the current employer for retention in the facility's personnel files. They must also ensure that copies of the continuing education training certificates, pursuant to subparagraph (a)2. of this subsection, are retained in their personnel files. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain the required trainings for the provision of the Limited Mental Health (LMH) services license. This was evidenced by the facility's failure to ensure that 26 of 50 staff (Staff B, Staff I, Staff M-S, Staff U-LL) completed the mandatory 6-hour initial and 3-hour biennial continuing education training approved by Department of Children and Families. The findings included: During an interview conducted with the Administrator on at 9:50 AM, she stated the facility had a license to provide limited mental health services. At this time, the most recent limited mental health trainings were requested for the Administrator and the direct care staff.	AL243		

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AL243	Continued From page 47 A review of the documentation (training certificates) provided by the Administrator revealed the following information: 1) Staff B (CNA) had a hire date of . There was no documentation provided for the completion of an initial 6-hour training nor the 3-hour biennial continuing education training. 2) Staff I (Med Tech) had a hire date of . There was no documentation provided for the completion of an initial 6-hour limited mental health services training nor the 3-hour biennial continuing education training. 3) Staff M (HHA) had a hire date of . There was no documentation provided for the completion of an initial 6-hour limited mental health services training. 4) Staff N (HHA) had a hire date of . There was no documentation provided for the completion of an initial 6-hour limited mental health services training. 5) Staff O (Med Tech) had a hire date of . There was no documentation provided for the completion of an initial 6-hour limited mental health services training. 6) Staff P (Med Tech) had a hire date of . There was no documentation provided for the completion of an initial 6-hour limited mental health services training nor the 3-hour biennial continuing education training. 7) Staff Q (Med Tech) had a hire date of . There was no documentation provided for the completion of an initial 6-hour limited mental health services training nor the 3-hour biennial continuing education training. 8) Staff R (Med Tech) had a hire date of .There was no documentation provided for the completion of an initial 6-hour limited mental health services training nor the	AL243		

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AL243	Continued From page 48 3-hour biennial continuing education training. 9) Staff S (Med Tech) had a hire date of . There was no documentation provided for the completion of an initial 6-hour limited mental health services training nor the 3-hour biennial continuing education training. 10) Staff U (HHA) had a hire date of .There was no documentation provided for the completion of an initial 6-hour limited mental health services training nor the 3-hour biennial continuing education training. 11) Staff V (Med Tech) had a hire date of . There was no documentation provided for the completion of an initial 6-hour limited mental health services training. 12) Staff W (Med Tech) had a hire date of . There was no documentation provided for the completion of an initial 6-hour limited mental health services training nor the 3-hour biennial continuing education training. 13) Staff X (Med Tech) had a hire date of . There was no documentation provided for the completion of an initial 6-hour limited mental health services training nor the 3-hour biennial continuing education training. 14) Staff Y (Med Tech) had a hire date of . There was no documentation provided for the completion of an initial 6-hour limited mental health services training. 15) Staff Z (Med Tech) had a hire date of . There was no documentation provided for the completion of an initial 6-hour limited mental health services training nor the 3-hour biennial continuing education training. 16) Staff AA (HHA) had a hire date of . There was no documentation provided for the completion of an initial 6-hour limited mental health services training nor the 3-hour biennial continuing education training. 17) Staff BB (HHA) had a hire date of .	AL243		

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AL243	Continued From page 49 There was no documentation provided for the completion of an initial 6-hour limited mental health services training nor the 3-hour biennial continuing education training. 18) Staff CC (HHA) had a hire date of .There was no documentation provided for the completion of an initial 6-hour limited mental health services training nor the 3-hour biennial continuing education training. 19) Staff DD (HHA) had a hire date of .There was no documentation provided for the completion of an initial 6-hour limited mental health services training. 20) Staff EE (HHA) had a hire date of . There was no documentation provided for the completion of an initial 6-hour limited mental health services training nor the 3-hour biennial continuing education training. 21) Staff FF (HHA) had a hire date of . There was no documentation provided for the completion of an initial 6-hour limited mental health services training nor the 3-hour biennial continuing education training. 22) Staff GG (HHA) had a hire date of . There was no documentation provided for the completion of an initial 6-hour limited mental health services training nor the 3-hour biennial continuing education training. 23) Staff HH (HHA) had a hire date of . There was no documentation provided for the completion of an initial 6-hour limited mental health services training nor the 3-hour biennial continuing education training. 24) Staff JJ (HHA) had a hire date of . There was no documentation provided for the completion of an initial 6-hour limited mental health services training. 25) Staff KK (HHA) had a hire date of . There was no documentation provided for the completion of an initial 6-hour limited mental	AL243		

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AL243	Continued From page 50 health services training. 26) Staff LL (HHA) had a hire date of . There was no documentation provided for the completion of an initial 6-hour limited mental health services training. During an interview conducted with the Administrator on at 2:41 PM, she stated that she was aware that the 26 direct care staff members (Staff B, Staff I, Staff M-S, Staff U-LL) had not completed the required trainings for the limited health services license at the time of survey. The Administrator acknowledged the findings. Class III	AL243		