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
	AL11965661	A. BUILDING: _____ B. WING _____	10/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS LAKE MARY	3655 W. LAKE MARY BLVD, LAKE MARY, FL 32746

(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 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement 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	A 032		

AHCA Form 3020-0001

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

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A 032	Continued From page 1 Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on interview, and record review, the facility failed to ensure 2 of 11 sampled staff, (Caregivers A and B), participated in a minimum of two resident elopement drills each year. Findings: 1. Review of Caregiver A's personnel record revealed a hire date of . Review of the resident elopement drills revealed she did not participate in any drills during 2024. 2. Review of Caregiver B's personnel record revealed a hire date of . Review of the resident elopement drills revealed she did not participate in any drills during 2024.	A 032		

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A 032	Continued From page 2 On at 1:21 PM, the findings were confirmed with the Maintenance Director, who said he did not have record of the 2024 elopement drills, because he threw them in the trash. Class III	A 032		
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	A 052		

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A 052	Continued From page 3 or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , ,. converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of	A 052		

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A 052	Continued From page 4 administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the	A 052		

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A 052	Continued From page 5 resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure unlicensed Caregivers (A and E) who assisted 4 of 4 sampled residents, (#6, #7, #13, and #14) with	A 052		

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A 052	Continued From page 6 medications, followed the correct procedures. Findings: On at 9:00 AM, unlicensed Caregiver A gave medications to resident #6. At 9:05 AM, she gave medications to resident #7. On at 11:15 AM, unlicensed Caregiver E gave medications to resident #13. At 11:18 AM, she gave medications to resident #14. Both unlicensed caregivers prepared the medications at the cart before placing the medication packages inside it. Neither caregiver said the name or dosage of each medication. On at 2:40 PM, unlicensed Caregiver A said residents #6 and #7 did not have a written waiver opting out of being told the name and dosage of the medications. She confirmed not preparing the medications in the resident's presence and said she knew she was supposed to. On at 1:30 PM, unlicensed Caregiver E said she did not know if residents #13 and #14 had a waiver opting out of being told the name and dosage of the medications. She did not recall learning she had to prepare the medications in the presence of the resident. She said during her facility training, the trainer did it the same way she did. Class III	A 052		

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A 054	Continued From page 7	A 054		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known ˘ the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on interview, and record review, the facility failed to ensure a medication observation record (MOR) was updated each time a medication was offered or administered for 1 of 15 sampled	A 054		

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A 054	Continued From page 8 residents, (#7). Findings: Review of resident #7's health assessment form (1823) dated , revealed he required assistance with self-administration of medications. Review of the resident's , MOR revealed his medications were not signed as given on . On at 8:36 AM, the Vice President (VP) of Clinical Services and Compliance acknowledged the findings. On at 11:27 AM, the Director of Resident Care acknowleged the findings. No additional documentation was provided by the facility. Class III	A 054		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container:	A 056		

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A 056	Continued From page 9 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a	A 056		

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A 056	Continued From page 10 written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to obtain a revised pharmacy label or place an "alert" label on the medication package to direct staff to examine the revised directions for use in the Medication	A 056		

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A 056	Continued From page 11 Observation Record (MOR) for 1 of 15 sampled residents, (#6), whose medication had a change in directions for use. Findings: On at 9:00 AM, unlicensed Caregiver A gave resident #6 one , tablet. The MOR directions were to give one tablet in the morning. The prescription label directions were to give one tablet of , every evening. Review of the resident record revealed on a health care provider ordered , to be given in the morning. On at 4:00 PM, further review of the prescription label revealed the prescription label had not been changed to reflect the new directions nor was an "alert" label placed to direct staff to examine the revised directions for use in the MOR. Unlicensed Caregiver B was present at that time, and acknowledged an "alert" label should have been placed on the bottle. Class III	A 056		
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 been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without	A 078		

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A 078	Continued From page 12 a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with	A 078		

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A 078	Continued From page 13 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 interview and record review, the facility failed to ensure 3 of 11 sampled staff (Caregivers A, B, and C), submitted a written statement from a health care provider documenting the individual did not have any signs or symptoms of communicable , and failed to ensure 2 of 11 sampled staff (Caregivers A, and B) had evidence of a negative ( ) exam on an annual basis. Findings: 1. Review of unlicensed Caregiver A's personnel record revealed a hire date of . The record contained a written statement from a health care provider dated documenting the caregiver did not have any signs or symptoms of communicable . There was no evidence of the required negative exam annually thereafter. On at 1:40 PM, the Vice President of Clinical Services and Compliance acknowledged	A 078		

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A 078	Continued From page 14 the findings but did not provide additional documentation. 2. Review of Caregiver B's personnel record revealed a hire date of . The record did not contain a written statement from a health care provider documenting the caregiver did not have any signs or symptoms of communicable . The record did not have documentation of an annual negative exam. 3. Review of Caregiver C's personnel record revealed a hire date of . The record did not contain a written statement from a health care provider documenting the caregiver did not have any signs or symptoms of communicable . On at 12:15 PM, the Vice President of Clinical Services and Compliance acknowledged the findings. On at 3:00 PM, the facility was unable to provide any additional documentation for Caregiver A, B or C. 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	A 081		

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A 081	Continued From page 15 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 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	A 081		

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A 081	Continued From page 16 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, 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	A 081		

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A 081	Continued From page 17 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 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 interview and record review, the facility	A 081		

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A 081	Continued From page 18 failed to ensure 3 of 11 sampled staff, (Caregivers A, B, and C) completed the minimum required training. Findings: 1. Review of Caregiver A's personnel record revealed a hire date of . The record did not contain evidence to indicate she received a minimum of one hour in-service training in control, including universal precautions and facility sanitation procedures and a minimum of one hour in-service training within 30 days of employment that covered recognizing and reporting resident , neglect, and . On at 1:40 PM, the Vice President of Clinical Services and Compliance acknowledged the findings, but could not provide additional documentation. 2. Review of Caregiver B's personnel record revealed a hire date of . The record did not include documentation to indicate the caregiver received a minimum of one hour in-service training within 30 days of employment that covered reporting adverse incidents and facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation; a minimum of one hour in-service training within 30 days of employment that covered recognizing and reporting resident , neglect, and , , using the facility's prevention policies and procedures when offering this training; in-service training regarding the facility's resident elopement response policies and procedures within 30 days of employment. The record had a total of a half hour of safe food handling, but there was no documentation to indicate the caregiver who	A 081		

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A 081	Continued From page 19 served food, received a minimum of one hour of in-service training in safe food handling practices within 30 days of employment . 3. Review of Caregiver C's personnel record revealed a hire date of . The record did not include documentation to indicate the caregiver received the minimum one hour in-service training within 30 days of employment that covered reporting adverse incidents and facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation; the minimum one hour in-service training within 30 days of employment that covered recognizing and reporting resident , neglect, and , using the facility's prevention policies and procedures when offering this training: in-service training regarding the facility's resident elopement response policies and procedures within 30 days of employment; three hours in-service training within 30 days of employment that covered resident behaviors and needs and providing assistance with the activities of daily living; and the minimum one hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. On at 12:15 PM, the Vice President of Clinical Services and Compliance acknowledged the findings. On at 3:00 PM, the Vice President of Clinical Services and Compliance said she did not have access to the documentation and was not able to provide the required documentation. Class III	A 081		

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A 082	Continued From page 20	A 082		
A 082 SS=D	59A-36.011(4) FAC Training - / (4) / (/). Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on and , including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 11 sampled staff (Caregiver C) completed a one-time education course on / , (/) within 30 days of employment. Findings: Review of Caregiver C's personnel record revealed a hire date of . The record did not contain a one-time education course on and within 30 days of employment as required. On at 12:15 PM, the Vice President of Clinical Services and Compliance acknowledged the findings. On at 3:00 PM, the Vice President of Clinical Services and Compliance said she did not have access to the documentation of the	A 082		

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A 082	Continued From page 21 required education. Class III	A 082		
A 083 SS=D	59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND ( ). A staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure a staff member who had completed the First Aid course had documentation to show the completion of the course was available at all times in the facility. Findings:	A 083		

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A 083	Continued From page 22 Review of the staff schedule for revealed no facility staff held a valid First Aid training documentation from 11:00 PM to 7:00 AM. On at 2:45 PM, the Vice President of Clinical Services and Compliance confirmed the findings, and acknowledged the requirement. Class III	A 083		
A 084 SS=D	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall	A 084		

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A 084	Continued From page 23 include demonstrations of proper techniques, including techniques for control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, , dosage forms, and , , , and dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with syringes that are prefilled with the proper dosage by a pharmacist and , that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection;	A 084		

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A 084	Continued From page 24 i. Assist with ; j. Use a to perform testing; k. Assist residents with and continuous positive airway pressure (CPAP) devices, excluding the titration of the levels; l. Apply and remove stockings and hosiery; m. Placement and removal of bags, excluding the removal of the or manipulation of the site; and, n. Measurement of rate, temperature, and rate. (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff assisting with the self-administration of medications under s. 429.256 must complete a	A 084		

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A 084	Continued From page 25 minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure 1 of 2 sampled unlicensed staff (Caregiver E) who assisted with self-administration of medications completed a minimum of six hours in person training. Findings: On at 11:15 AM, unlicensed Caregiver E gave medications to resident #13. A few minutes later at 11:18 AM, Caregiver E gave medications to resident #14. Review of unlicensed Caregiver E's personnel record revealed a hire date of . The personnel record revealed her six-hour training in assisting with self-administration of medications dated was obtained online and not in person, as required. On at 10:43 AM, Caregiver E confirmed the training was completed online, not in person. Class III	A 084		
A 090 SS=D	59A-36.011(11) FAC Training - (11) TRAINING.	A 090		

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A 090	Continued From page 26 (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 interview and personnel record review, the facility failed to ensure 2 of 11 sampled staff (Caregivers B, and C) received at least one hour of training about the facility's policy and procedures regarding ( ) within 30 days after employment. Findings: Review of Caregiver B's personnel record revealed a hire date of and Caregiver C's hire date of . Both personnel records revealed they did not include documentation to indicate the Caregivers received at least one hour of training in the facility's policy and procedures for within 30 days after employment. On at 12:15 PM, the findings were discussed with the Vice President of Clinical Services and Compliance, who acknowledged the findings. On at 2:45 PM, no additional	A 090		

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A 090	Continued From page 27 documentation was provided by the facility. Class III	A 090		
A 093 SS=D	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or	A 093		

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SPRING HILLS LAKE MARY	3655 W. LAKE MARY BLVD, LAKE MARY, FL 32746

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A 093	Continued From page 28 a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal.	A 093		

Agency for Health Care Administration

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A 093	Continued From page 29 (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on interview and record reviews and interviews, the facility failed to maintain six months of dated, signed menus by a licensed dietician. Findings: The Dining Manager was asked to provide six	A 093		

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A 093	Continued From page 30 months of dated, signed menus and substitution log for review. On at 11:52 AM, the Dining Manager stated, "I don't have six months' worth of menus. I was not told I needed to keep them." The manager explained the email with the new menus was received they changed the dates for each week before printing them out, and the substitution log was kept in the binder. On at 3:07 PM, the Vice President of Clinical Services and Compliance stated the Dining Manager was aware the menus needed to be maintained due to the audit that was recently conducted. The Vice President confirmed the facility should have maintained six months of menus. The Dining Manager was only able to provide copies of a four-week cycle of undated menus. (photographic evidence obtained) Class III	A 093		
AN278 SS=D	59A-36.022(3) FAC; 429.07(3)(c)2, FS LNS - Records 59A-36.022 (3) RECORDS. (a) A record of all residents receiving limited nursing services and the type of services provided must be maintained at the facility. (b) Nursing progress notes must be maintained for each resident who receives limited nursing services from facility staff. (c) A nursing assessment conducted at least monthly must be maintained on each resident	AN278		

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AN278	Continued From page 31 who receives a limited nursing service. 429.07 (3)(c)2, FS A facility that is licensed to provide limited nursing services shall maintain a written progress report on each person who receives such nursing services from the facility's staff. The report must describe the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health... This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure nursing progress notes were maintained for 1 of 2 sampled residents, (#12), who received Limited Nursing Services (LNS.) Findings: On at 9:45 AM, the Vice President (VP) of Clinical Services and Compliance provided a list of residents who received LNS. Resident #12 was on the list for use of , , , , , stockings. Review of the resident's record revealed a health care provider's order, dated , for , stockings to both lower during the day and to be off at night. A facility level of care document, dated , indicated the resident used , stockings; required staff assistance with application of the stockings and for staff monitoring from an appropriately skilled professional one to two times per day. The record did not contain nursing progress notes for use of the stockings as required. On at 1:15 PM, the findings were	AN278		

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AN278	Continued From page 32 discussed with the VP of Clinical Services and Compliance. At 1:54 PM, she returned and said the company never maintained nursing progress notes when a resident received LNS. Class III	AN278		
ZZ000	Initial Comments	ZZ000		
ZZ841 SS=D	408.823( ) FS In-person Visitation (1) This section applies to , centers as defined in s. 393.063, hospitals licensed under chapter 395, nursing home facilities licensed under part II of chapter 400, hospice facilities licensed under part of chapter 400, intermediate care facilities for the , , licensed and certified under part VIII of chapter 400, and assisted living facilities licensed under part I of chapter 429. (2)(a) No later than 30 days after the effective date of this act, each provider shall establish visitation policies and procedures. The policies and procedures must, at a minimum, include control and education policies for visitors; screening, personal protective equipment, and other control protocols for visitors; permissible length of visits and numbers of visitors, which must meet or exceed the standards in ss. 400.022(1)(b) and 429.28(1)(d), as applicable; and designation of a person responsible for ensuring that staff adhere to the policies and procedures. Safety-related policies and procedures may not be more stringent than those established for the provider's staff and may not require visitors to submit proof of any	ZZ841		

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ZZ841	Continued From page 33	ZZ841		

or immunization. The policies and procedures must allow consensual physical contact between a resident, client, or patient and the visitor.
(b) A resident, client, or patient may designate a visitor who is a family member, friend, guardian, or other individual as an essential caregiver. The provider must allow in-person visitation by the essential caregiver for at least 2 hours daily in addition to any other visitation authorized by the provider. This section does not require an essential caregiver to provide necessary care to a resident, client, or patient of a provider, and providers may not require an essential caregiver to provide such care.
(c) The visitation policies and procedures required by this section must allow in-person visitation in all of the following circumstances, unless the resident, client, or patient objects:
1. End-of-life situations.
2. A resident, client, or patient who was living with family before being admitted to the provider ' s care is struggling with the change in environment and lack of in-person family support.
3. The resident, client, or patient is making one or more major medical decisions.
4. A resident, client, or patient is experiencing emotional distress or grieving the loss of a friend or family member who recently .
5. A resident, client, or patient needs cueing or encouragement to eat or drink which was previously provided by a family member or caregiver.
6. A resident, client, or patient who used to talk and interact with others is seldom speaking.
7. For hospitals, childbirth, including labor and delivery.
8. patients.
(d) The policies and procedures may require a

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ZZ841	Continued From page 34 visitor to agree in writing to follow the provider's policies and procedures. A provider may suspend in-person visitation of a specific visitor if the visitor violates the provider's policies and procedures. (e) The providers shall provide their visitation policies and procedures to the agency when applying for initial licensure, licensure renewal, or change of ownership. The provider must make the visitation policies and procedures available to the agency for review at any time, upon request. (f) Within 24 hours after establishing the policies and procedures required under this section, providers must make such policies and procedures easily accessible from the homepage of their websites. This Statute or Rule is not met as evidenced by: Based on interview, and record review the facility failed to ensure its visitation policy and procedure, and website contained all the required minimum provisions. Findings: Review of the facility's visitation policies and procedures dated , and their website revealed they did not include the allowance of in-person visitation in all of the following circumstances: 1. A resident who was living with family before being admitted to the provider's care is struggling with the change in environment and lack of in-person family support. 2. The resident is making one or more major medical decisions. 3. A resident is experiencing emotional distress or grieving the loss of a friend or family member who recently .	ZZ841		

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ZZ841	Continued From page 35 4. A resident needs cueing or encouragement to eat or drink, which was previously provided by a family member or caregiver. 5. A resident who used to talk and interact with others is seldom speaking. On at 1:12 PM, the Vice President of Clinical Services and Compliance after review of the policy acknowledged the lack of the required allowances and said, "I don't see it and [I will] tell whoever needs to know so that they can get it updated." On at 3:07 PM, the Vice President of Clinical Services and Compliance and Director of Resident Care confirmed the findings. (photographic evidence obtained) Class III	ZZ841		
ZZ875 SS=D	430.5025(4 &) / ; Training (4) Employees of covered providers must complete the following training for 's and related forms of : (a) Upon beginning employment, each employee must receive basic written information about interacting with persons who have 's or related forms of . . (b) Within 30 days after beginning employment, each employee who provides personal care to or has regular contact with participants, patients, or residents must complete a 1-hour training program provided by the department. 1. The department shall provide training that is available online at no cost. The 1-hour training program shall contain information on	ZZ875		

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ZZ875	Continued From page 36 understanding the basics about the most common forms of , how to identify the signs and symptoms of , and skills for communicating and interacting with persons with ' s or related forms of . A record of the completion of the training program must be made available to the covered provider which identifies the training curricula, the name of the employee, and the date of completion. 2. A covered provider must maintain a record of the employee's completion of the training program and, upon written request of the employee, provide the employee with a copy of the record of completion consistent with the employer's written policies. 3. An employee who has completed the training required in this subsection is not required to repeat the program upon changing employment to a different covered provider. (c) Within 7 months after beginning employment for a home health agency, nurse registry, or companion or homemaker service provider, each employee who provides personal care must complete 2 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person ' s independence in activities of daily living, and skills in working with families and caregivers. (d) Within 7 months after beginning employment for a nursing home, an assisted living facility, an adult family-care home, or an adult day care center, each employee who provides personal care must complete 3 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living,	ZZ875		

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ZZ875	Continued From page 37	ZZ875		

skills in working with families and caregivers, group and individual activities, maintaining an appropriate environment, and ethical issues.
(e) For an assisted living facility, adult family-care home, or adult day care center that advertises and provides, or is designated to provide, specialized care for persons with 's or related forms of , in addition to the training specified in paragraphs (a) and (b), employees must receive the following training:
1. Within 3 months after beginning employment, each employee who provides personal care to or has regular contact with the residents or participants must complete the additional 3 hours of training as provided in paragraph (d).
2. Within 6 months after beginning employment, each employee who provides personal care must complete an additional 4 hours of -specific training. Such training must include, but is not limited to, understanding and related forms of , the stages of 's , communication strategies, medical information, and stress management.
3. Thereafter, each employee who provides personal care must participate in at least 4 hours of continuing education each calendar year through contact hours, on-the-job training, or electronic learning . For this subparagraph, the term "on-the-job training" means a form of direct coaching in which a facility administrator or his or her designee instructs an employee who provides personal care with guidance, support, or -on experience to help develop and refine the employee's skills for caring for a person with 's or a related form of . The continuing education must cover at least one of the topics included in the -specific training in which

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ZZ875	Continued From page 38 the employee has not received previous training in the previous calendar year. The continuing education may be fulfilled and documented in a minimum of one quarter-hour increments through on-the-job training of the employee by a facility administrator or his or her designee or by an electronic learning [illegible] chosen by the facility administrator. On-the-job training may not account for more than 2 hours of continuing education each calendar year. (f)1. An employee provided, assigned, or referred by a health care services pool must complete the training required in paragraph (c), paragraph (d), or paragraph (e) that is applicable to the covered provider and the position in which the employee will be working. The documentation verifying the completed training and continuing education of the employee, if applicable, must be provided to the covered provider upon request. 2. A health care services pool must verify and maintain documentation as required under s. 400.980(5) before providing, assigning, or referring an employee to a covered provider. (7) For a certified nursing assistant as defined in s. 464.201, training hours completed as required under this section may count toward the total hours of training required to maintain certification as a nursing assistant. (8) For a health care practitioner as defined in s. 456.001, training hours completed as required under this section may count toward the total hours of continuing education required by that practitioner's licensing board. (9) Each person employed, [illegible], or referred to provide services before [illegible] must complete the training required in this section before [illegible]. Proof of completion of equivalent training completed before [illegible] shall substitute for the training required in	ZZ875		

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ZZ875	Continued From page 39 subsection (4). Each person employed, , or referred to provide services on or after , may complete training using approved curriculum under paragraph (5)(d) until the effective date of the rules adopted by the department under subsection (6). This Statute or Rule is not met as evidenced by: Based on interview, and record review, the facility failed to ensure 3 of 11 sampled staff (Caregivers C, I, and M) completed a one-hour training on and related forms of (ADRD) provided by the Department of Elderly Affairs within 30 days of employment. Findings: 1. Review of Caregiver I's personnel record revealed a hire date of . The record did not contain evidence the caregiver completed the required one hour training on ADRD provided by the Department of Elderly Affairs within 30 days of employment. On at 9:08 AM, the Vice President of Clinical Services and Compliance, acknowledged the findings, but did not provide additional documentation. 2. Review of Caregiver C's personnel record revealed a hire date of . The record did not include a one-hour training on 's or related forms of provided by the Department of Elder Affairs or the additional required hours of ADRD training. On at 12:15 PM, and 3:00 PM, the Vice President of Clinical Service and Compliance acknowledged the findings and confirmed she had no additional documents to show compliance	ZZ875		

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ZZ875	Continued From page 40 with this requirement. 3. Review of Caregiver M's personnel record revealed a hire date of . The record did not contain evidence Caregiver M completed the required one-hour training on ADRD provided by the Department of Elderly Affairs within 30 days of employment at the facility. On at 11:35 AM, in a telephone conference the Vice President of Clinical Services and Compliance; the Administrator; and the Director of Resident Care confirmed the findings. Class III	ZZ875		
A 000	Initial Comments Re-licensure, complaint #2025014260 and generator monitoring surveys were conducted at Spring Hills Lake Mary from - . The facility had deficiencies at the time of the survey. The complaint identified Class I deficiency at A0030 and Class II deficiency at 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. A 0030 Resident Rights and Facility Procedures The facility failed to honor resident rights by failing to provide a safe environment, free from	A 000		

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A 000	Continued From page 41 for 5 of 18 sampled residents (5, 14, 20, 24, 27) and failed to follow their resident and neglect policy. The facility's Vice President of Clinical Services and Compliance, Administrator, and Director of Resident Care were notified of the Class I noncompliance on at 11:35 AM via phone. The census at the start of the survey was 88	A 000		
A 008 SS=D	429.26( ) FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner's direct observation of the patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the	A 008		

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	AL11965661	A. BUILDING: _____ B. WING _____	10/03/2025

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A 008	Continued From page 42 appropriateness of the resident's admission to or continued residency in the facility. The medical examination form, reflecting the resident's condition on the date the examination is performed, becomes a permanent part of the facility's record of the resident and must be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or , , nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided	A 008		

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A 008	Continued From page 43 that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of , , require such assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a -to- medical examination completed by a health care practitioner as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 days before or within 30 days after the individual's admission to a facility pursuant to Section 429.26(5), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations, 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living, 3. Any nursing or , , services required by the individual, 4. Any special diet required by the individual, 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication,	A 008		

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A 008	Continued From page 44 6. Whether the individual has signs or symptoms of , , , , or any other communicable , which are likely to be transmitted to other residents or staff, 7. A statement on the day of the examination that, in the opinion of the examining health care practitioner, the individual's needs can be met in an assisted living facility; and, 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care practitioner. (b) When a health care practitioner conducts a medical examination, the examination must be recorded on the practitioner's form or on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, , , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-13531. Faxed or electronic copies of the completed form are acceptable. If AHCA Form 1823 is used, the form must be completed as instructed. 1. If the health care practitioner's form does not include all the examination items on AHCA Form 1823 or if AHCA Form 1823 is not completed fully, then the omitted items may be obtained by the administrator or designee either orally or in writing from the health care practitioner. The missing or omitted information must be obtained and documented in the resident's record within 30 days after the resident's admission to the facility. 2. Omitted or missing information received orally must include the name of the health care practitioner, the name and signature of the administrator or designee recording the information, and the date the information was provided.	A 008		

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A 008	Continued From page 45 (c) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (d) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.26, F.S. and this rule. (e) Any orders issued by the health care practitioner conducting the medical examination for medications, nursing services, treatments, , , , or therapeutic diets, may be attached to the health assessment. A health care practitioner may attach a DH Form 1896, Florida Form, for residents who do not wish , , to be administered in the case of or , , . (f) A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on interview, and record review, the facility failed to ensure a health assessment form (1823)	A 008		

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A 008	Continued From page 46 was complete for 1 of 15 sampled residents, (#25). Findings: On , review of resident #25's 1823 health assessment dated revealed it was missing information for physical, sensory limitations, or behavioral status and nursing/treatment/ service requirements. Further review revealed resident #25 returned from the hospital on at 6:37 PM. There was no documentation in the record to indicate the facility contacted a health care provider to obtain the missing information. On at approximately 12:30 PM, the Vice President of Clinical Services and Compliance acknowledged the findings and explained resident #25 had a hospital visit and that was the 1823 that was provided. (photographic evidence obtained) Class III	A 008		
A 010 SS=D	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the	A 010		

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A 010	Continued From page 47	A 010		

resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility:
(a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party.
(b) A facility may admit or retain a resident who requires the use of assistive devices.
(c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the 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

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A 010	Continued From page 48 physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 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	A 010		

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A 010	Continued From page 49 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A ill resident who no longer meets the criteria for continued residency may continue 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	A 010		

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A 010	Continued From page 50 interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on interview and record reviews, the facility failed to obtain a new Agency for Health Care Administration (AHCA) Form 1823, Health Assessment completed by the healthcare provider for continued residency after a significant change for 1 of 7 sampled residents, (#16), as required in an assisted living facility (ALF). Findings: Review of resident #16's record revealed a facility admission date of . An 1823 health assessment dated revealed a medical history of , acute hard of hearing with no indication of hospice	A 010		

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A 010	Continued From page 51 services. On at 2:00 PM, the Vice President of Clinical Services and Compliance stated, "I believe resident #16 moved into the facility on hospice and the facility did not obtain an initial care plan or an 1823." Review of resident #16's Senior Communities Resident Evaluation & Level of Care dated under Special Clinical Needs #7 indicated the resident required the services of hospice. Review of Hospice Care Plan revealed on resident #16 was removed from hospice due to traveling /leave of absence. Further review revealed a readmission start date on of the ALF/Hospice Care Plan. On at 11:58 AM, the Director of Resident Care stated, she didn't know she needed a new 1823 for resident #16 when the resident returned from leave. The Director explained the resident was still their resident, but was just on vacation with her family. The Director said the resident moved into the facility under hospice. The Director of Resident Care acknowledged the regulations pertaining to significant changes related to admission and discharge services to hospice required the 1823 form to be updated. (photographic evidence obtained) Class III	A 010		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision	A 025		

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A 025	Continued From page 52 429.26 (7) The facility shall notify a licensed physician 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.	A 025		

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A 025	Continued From page 53 (d) Contacting the resident's health care provider and other appropriate party such as the resident's 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, interview, and record review, the facility failed to provide care and services for adequate supervision to ensure safety through proactive measures to minimize the potential for with injuries, for 2 of 15 sampled residents, (#14, and #20); and failed to provide adequate supervision to prevent physical altercations, for 2 of 2 sampled residents, (#24, and #25). Additionally the facility failed to follow its policy on periodic resident checks for 1 of 15 sampled residents, (#16), and failed to ensure a health care provider's order for application of , stockings was followed for 1 of 2 sampled residents, (#12). Findings: 1. The facility's undated reduction and response to policy, last revised , indicated, a risk assessment would be completed upon admission, every 180 days, or after a change in condition. If deemed necessary, a plan would be implemented to minimize the	A 025		

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A 025	Continued From page 54 risk of . A resident evaluation of conditions and factors that increased the risk of falling was to be completed on admission, every 180 days, or a change in condition and after a . The policy indicated risk evaluation score or risk would be entered on the individualized service plan and the results of the evaluation were used to formulate a plan for reduction. The document detailed that after a , the Director of Resident Care or a qualified person must show documentation of an analysis of the circumstances of the and interventions that were initiated to prevent or reduce the risk of subsequent . Review of the risk assessment document, a score of 45 and higher was considered high risk. Review of resident #14's record revealed a facility admission date of . Her medical history included with agitation. The 1823 dated indicated a special precaution for ; the resident transferred and ambulated independently. The form detailed the resident had a physician order for the thinning medication, , and she received hospice services. Review of the resident's record revealed documentation that on at 7:26 AM, the resident reported, "I in the bathroom. I feel ," Staff documented the resident was observed limping in her room. The resident told staff she in the bathroom and didn't know what happened. Staff documented the resident could not stop shaking, she was breathing deeply and her level on room air was low at 89%. The documentation included that after deep breathing her level increased to 90%, but it dropped down to 89% so she was sent to the hospital. She returned around 2:00 PM.	A 025		

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A 025	Continued From page 55 A few weeks later on at 8:34 AM, staff documentation revealed resident #14 was observed sitting on her couch with on her . She had a four inch on the front of her and a two inch on the of her . The resident reported to staff she was in the bathroom, felt hot then . The record showed she was sent to a hospital. Staff documented the resident returned to the facility with 26 stitches on the front of her later that afternoon at 3:35 PM. Staff did not document how many stitches resident #14 received on the of her . The record showed on she refused , , , and on a care conference was held with her family, who agreed to move her from assisted living to memory care. On at 11:02 AM, another was reported. Staff documentation indicated the resident said she and hit her on a desk. She refused to allow staff to look at her . A few weeks later on at 12:47 PM, resident #14 reported she had the night before. Documentation indicated the resident got up in the middle of the night, slipped on the rug next to her bed and hit her right , . The resident complained her , was . Resident #14's record revealed on at 2:50 PM, she and hit her . The resident reported she passed out, and ; were seen on both arms as well as an open area on her forehead. She complained of right , , and was sent to the hospital. Review of the 1823 dated indicated	A 025		

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A 025	Continued From page 56 resident #14 had a new diagnosis of right . On she returned to the facility now ambulating with a walker. Staff documented that on at 11:07 AM, resident #14 was heard yelling in the hallway saying her , hurt. Staff described that was seen in her left and she was unable to say what happened. The resident was sent to the hospital and she returned at 6:45 PM, with one suture in her left . The next day on at 12:00 PM, resident #14 was observed lying on the floor of her bedroom as documented by staff. They detailed she was fully dressed with fuzzy socks on and no shoes. Later that afternoon at 5:30 PM, she was observed laying on the floor in her bedroom. The resident was unable to give details of what happened, but was able to report she hit her and was in , . Resident #14 did not want to be moved, so 911 was called and she was transported to the hospital. Documentation revealed on at 10:00 AM, the resident was again observed laying on her on the floor of her bedroom wearing fuzzy socks. She refused assistance and wanted to remain in bed. Her family was present and was asked to bring in non-slip socks. Three days later on at around 11:30 PM, resident #14 again. Staff documentation revealed she said she had sharp , in her , and severe , , so she was sent to a hospital. She returned the next morning. Resident #14's record revealed on at 11:35 AM, resident #14 again went to the	A 025		

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A 025	Continued From page 57 bathroom and . She was found between her recliner and bed. The record indicated the resident had a , spell and was lowered to the floor in and in , was sent to the hospital after hitting her . The record revealed from to , resident #14 13 times, including seven trips to the hospital, and one / , . Resident #14's risk assessments conducted on , , , , and all scored 55 (high risk). No additional assessments were provided. Review of resident 14's service plan revealed interventions were to , and meet the resident's needs and ensure she was wearing appropriate footwear, non-skid socks or shoes when ambulating or mobilizing in a wheelchair. The plan indicated she had a history of within the past year and required a prevention plan. On at 1:00 PM, resident #14's plan, resident evaluation, and the analysis completed after each was requested from the facility. On at 1:20 PM, the Vice President of Clinical Services and Compliance said resident #14 did not have a plan. None of the other requested documents were provided. 2. Review of resident #20's record revealed a facility admission date of . His medical history included 's . A 1823 form indicated he had recurrent and needed precautions. The form detailed resident #20 needed assistance with transferring and ambulation. Continued review of his record revealed the	A 025		

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A 025	Continued From page 58 resident at least 13 times in the six months from to , including: On at 5:07 PM, the resident in the living room. He was unsure what happened. A note, dated , indicated he in the bathroom on the night before. He sustained a on his right arm. On at around 4:30 AM, he was observed on the floor. He complained of , all over, and 911 was called. The responding emergency personnel determined he did not need to go to a hospital. On at 7:50 PM, he was found on the floor in a hallway. He sustained a on his left On a health care provider ordered , , , for strengthening, gait, and balance. On at 5:30 PM, he in the bathroom. On he was seen on the floor in the common area. He could not describe what happened. On at 10:40 PM, he was seen lying on the floor of his room. He was assisted to bed. On at 11:25 PM, he and sustained a on the right side of his forehead. He was agitated and fought with staff, 911 was called and he was taken to a hospital. On he was admitted to hospice services.	A 025		

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A 025	Continued From page 59 On a health care provider ordered , , , for three sessions for safe transferring. On at 6:07 PM, he behind a couch. On at 7:09 PM, he was found on the floor and sustained a on his right . On at 4:00 AM, he was seen kneeling in front of his bed on the floor mat trying to get into bed. Redness was seen on his . On at 9:15 PM, he was on the floor next to his bed. His right gave out during a transfer into bed. On at 3:00 PM, he in the bathroom. He sustained a on his left . risk assessments were conducted on , , and all scored 65 (high risk). Assessments on , , and all scored 80. Assessments on , , , , and all scored 55. A resident evaluation, dated , indicated a plan was required based on resident needs. No additional evaluations were done after each . Review of the resident #20's service plan revealed interventions were to , and meet the resident's needs, educate the resident/family/caregivers about safety reminders and what to do if a occurred, follow community protocol. , , , , to evaluate and treat as ordered, and required	A 025		

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A 025	Continued From page 60 observation from staff for safety needs. On at 1:00 PM, a request was made to review resident #20's plan and the analysis completed after each . The requested documents were not provided. On at 11:39 AM, Licensed Practical Nurse (LPN) G said resident #20's occurred mostly during the 11 PM to 7 AM shift. The nurse explained that when the resident started moving around in the bed, the caregivers were supposed to toilet him then take him to the common area for closer supervision. The LPN said the resident had a mat, but he did not retain information well, such as being told to call for assistance before getting up. The LPN said resident #14 had a hospital bed and a mat. The LPN explained resident #14 also retained very little information. The LPN had access to each resident's service plan. On at 11:56 AM, Caregiver T said resident #20 was more of a risk than #14. Resident #14 was more independent. The caregiver reported resident #20 should be checked on at least every two hours because he tried to get out of bed, but he had a mat. The caregiver said that residents in memory care did not have a call system and did not know when they needed help, so the staff had to , their needs. The caregiver did not know if he had access to the resident service plans because he never tried to review them. On at 12:56 PM, Caregiver M said he assisted resident #20 with care and ensured the resident always used his wheelchair. Caregiver M explained a floor mat was used to avoid injuries because resident #20 got out of bed and staff	A 025		

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A 025	Continued From page 61 would find him in the bathroom on the floor. Caregiver M reported that due to resident #14's temperament he did not assist her with activities of daily living. He monitored her throughout the day to see if she could walk or if she needed the wheelchair. The caregiver said resident service plans were not available to the caregivers. 3. Review of resident #12's record revealed a medical history of Lymphedema. On a health care provider ordered , stockings to be applied for both during the day and taken off at night. A level of care form indicated the resident wore , stockings; required staff assistance with application of the stocking; and needed staff monitoring from an appropriately skilled professional one to two times per day. On at 10:10 AM, the resident was sitting in the dining room. He was not wearing , stockings and said he was unaware that he was supposed to. On at 3:10 PM, Caregiver F said she did not put the stockings on him today. She explained when she did, he usually removed them. On at 3:37 PM, LPN G said the resident put the stockings on himself and was usually compliant with wearing them. The nurse said the only thing she did was look to see if he had them on, but explained she did not check today. She said Caregiver F did not tell her she did not put them on today. On at 3:45 PM, the resident was observed sitting on a sofa in his room wearing	A 025		

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A 025	Continued From page 62 only regular socks, not the , stockings. He lifted both pant ˬ up to reveal both lower extremities were edematous. 4. Review of the revised , document Resident Care, Periodic Checks revealed residents would be provided with monitoring and periodic checks when needed as a means of providing a safe and secure living environment. The document described that all residents would be monitored 24 hours a day while they were in the community. Residents' would be visited by a staff member throughout the day and night, unless otherwise specified, at the residents' request. Should a resident not wish to have checks during the evening and night hours, a "Do Not Disturb" notice could be signed with the approval of the Director of Resident Care. Review of resident #16's [Hospice name] Hospice Nursing Visit Note indicated they were unable to do any work and considerable assistance was required. Review of resident #16's record revealed a facility admission on . An 1823 health assessment dated revealed a medical history of , , , , acute , , , , hard of hearing, forgetful, alert and oriented, no indication of hospice services, needs supervision with ambulation, bathing, ˬ, toileting, and transferring. Review of resident #16's , Medication Observation Record revealed she received her last medication pass at 9:00 PM from unlicensed Caregiver B.	A 025		

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A 025	Continued From page 63	A 025		

An incident report dated indicated that at approximately 9:20 AM, Caregiver A went to administer morning medications and remind the resident about breakfast. The report noted the resident was lying down on the floor with surrounding her , the nurse was called, the resident was assessed, and 911 was called. Upon further investigation, the resident was last checked on at 5:00 AM by care staff but reported no care was needed.

On at 3:04 PM, Caregiver A stated resident #16 was a little bit spunkier the day before. The caregiver said she saw the resident in the morning when it was time for her medications and they did not see her again until the next day when she was found on the floor.

On at 3:59 PM, Caregiver C stated, "I didn't check on her at 5:00 AM that day." The caregiver questioned that maybe it was Caregiver N who rounded on the resident, because she would sometimes help with making rounds. The caregiver said resident #16 was an independent resident, and recalled that one day during rounds, when she opened the door resident #16 said I didn't need to check on her. After that the caregiver said she didn't round on resident #16 at all that night, but found out when she returned to work what had happened.

On at 9:32 AM, Caregiver F stated, "I got sidetracked that day and didn't do my rounds. I didn't check on her that day." She explained she was running late and when she arrived she attended to the residents whose pagers were going off first. The caregiver said after that she started with the total care residents who needed assistance with getting up and showered, so that they could make it to breakfast. She explained

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A 025	Continued From page 64 that normally resident #16 was independent and didn't really push her button for assistance. On at 9:40 AM, resident #16's Power of Attorney (POA) confirmed the facility notified him of the , and they notified hospice and resident #16's doctor. On at 11:58 AM, the Director of Resident Care stated she was unaware the resident had asked not to be checked on for the past two months by staff. The Director confirmed that caregivers need to notify the Administration staff if a resident informed them that they do not want to be disturbed during the night. On at 12:56 PM, Caregiver N stated she did not check on resident #16 at all. She said when she was trained by a former staff she had been told that the independent residents did not need to be checked on overnight and that resident #16 was independent. She recalled, in the beginning, when she worked with Caregiver C, she would go around with her but she only assisted her if she asked for help. She explained now she worked the 1st floor and was not assigned to the 2nd. On at 2:03 PM, LPN G stated she saw the resident the night before when she came to get her medications. The resident informed the nurse that her was hurting between 8:30 and 9:00 PM. She recalled she left at 9:00 PM that night and couldn't remember where she was, but was sure she informed unlicensed Caregiver B she wanted her medications before she left. On at 1:50 PM, Caregiver O stated she saw resident #16 around 8:00 PM or maybe 8:30 PM. She requested assistance and went to check	A 025		

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A 025	Continued From page 65 on her. She stated the resident didn't feel good and needed her medications, so Caregiver O said she went to tell LPN G the resident was not feeling well and was crying. The caregiver explained the resident walked independently, and was in her room standing up. The caregiver recalled she didn't go to the room after that nor did she see her again that night. Review of the Call Performance Summary with a date range of to revealed resident #16's apartment did not show evidence of any call pendant responses. On at 2:11 PM, the Director of Resident of Care stated when Caregiver C was called, she originally stated she did rounds at 5:00 AM. The Director said after she spoke with the Vice President (VP) of Clinical Services and Compliance, Caregiver C arrived to the facility, and confirmed after reviewing resident #16's photo she said she did not check on her. She explained Caregiver B stated she saw the resident during the time when she received her evening medications. The Director said we just found out the staff was not checking on her. She explained Caregiver O told them that the resident pushed her call pendant, but said they didn't interview anyone else. The VP of Clinical Services and Compliance stated they pulled the call report and found no evidence of resident #16 calling for help. The VP said that Unlicensed Caregiver B confirmed she did see resident #16 when giving medications at 9:00 PM and that was the last time she saw her. She confirmed they did not have Caregiver B write a statement. On at 3:07 PM, the Vice President of Clinical Services and Compliance and the Director of Resident Care stated there was no	A 025		

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A 025	Continued From page 66 evidence the facility obtained a "Do Not Disturb" notice for resident #16. On at 11:05 AM, the Director of Resident Care stated resident #16 was not deemed as independent and she required assistance. She confirmed that hospice residents were not considered as independent and explained the resident would call us if she had any unmet needs. The Director reported that staff knew they were supposed to do checks on her. She conveyed the resident didn't need help with toileting and , but if she did she would call for assistance, but when the staff would go in she would tell them she didn't need any help. The facility failed to follow their policy for Periodic Checks monitoring all residents 24 hours a day while in the community throughout the day and during the night. 5. Review of resident #24's 1823 health assessment dated indicated a diagnosis of , was alert and oriented to self, and had , of cognition and memory. Review of resident #24's 1823 health assessment dated indicated a diagnosis of , but was left blank for or behavioral status. Review of a incident report revealed it was reported that resident #24 was restless and approached another resident yelling, then pushing him; then the other resident pushed , causing resident #24 to bump the left side of his forehead on a wall. The resident description indicated, "he was kicking out the intruder."	A 025		

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A 025	Continued From page 67 Another notification revealed, the family reported that resident #24 had issues in the past with male roommates or residents in previous communities as he the facility with being at home and thought the roommate was intruding. Review of a video dated , at approximately 7:40 AM, revealed that leading up to the altercation, resident #24 propelled himself in his wheelchair entering into the common area near the dining room. The video footage showed resident #24 continued into the common area, stopping along the walkway where resident #25 sat in a blue recliner. The video revealed the residents had words with each other, but it was unclear what was said. Resident #24 then lifted his as he continued to propel away, and resident #25 continued with the conversation. Resdient #25 then stood up, and resident #24 extended his stating, "you better sit down before..." the rest of the conversation was then unclear. The footage showed resident #25 then struck resident #24's ; Caregiver S sat nearby with another resident, immediately went over and stood in between the two residents stating, we're not fighting, sending resident #24 away. Further review of the video at approximately 7:54 AM, revealed resident #24 reentered the common area again along the hallway near the piano. Resident #24 propelled himself in his wheelchair towards resident #25 who still sat in the blue recliner along the walkway. Caregiver E was standing at the medication cart with her to the hallway where resident #24 entered the area. Resident #24 approached resident #25 pointed his , expressing himself with words while he continued to propel towards resident #25. Resident #25	A 025		

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A 025	Continued From page 68	A 025		

appeared to move his in an outward motion, with what sounded like, him telling resident #24 to go. Resident #25 proceeded to stand up from a sitting position moving towards resident #24 as the resident rolled in his wheelchair. Resident #24 put his left arm up, extending his towards resident #25. Resident #25 placed his on his , and stated "I'm not scared." The footage revealed resident #24 then reached out and grabbed the string on resident #25's hooded sweatshirt. The two residents proceeded to throw punches toward each other. While still holding on to one another, resident #25 threw several punches at resident #24, striking him on the . Resident #24's wheelchair rolled around, causing resident #25 to into the chairs. While resident #25 lost his balance, he continued hitting resident #24, striking him on his right lower jaw. Caregiver E was seen to immediately come over to break up the fight and get in between the residents. She was seen helping resident #25 up, asked him to sit down in the chair nearby while comforting him, then asked resident #24 if he was ok as well.

On at 10:24 AM, Caregiver S stated, she didn't witness what happened, except resident #25 had been sitting in the blue recliner, then resident #24 came in to the common area, approached resident #25 and was about to get "into it". She explained she separated them the first time. The caregiver recalled, "Resident #25 talks to himself all the time. I sent resident #24 away. I left and went to the bathroom. When I returned caregiver E told me they got into it. I stayed with them while Caregiver E called LPN K. I checked resident #24's because he had a bump and took a picture. I told the Director of Resident Care and LPN K. Afterwards, I paid attention to resident #24 and #25 keeping them

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A 025	Continued From page 69 away from one another. Resident #25 is the type of resident who tries to stand up for himself and will if he thinks you're trying to him." On at 10:35 AM, Caregiver E stated earlier that day resident #24 kept rolling over there throughout the day and kept saying things that might instigate a fight. She recalled other staff told her that resident #24 and #25 got into it. The caregiver recalled, "I didn't hear the commotion. While doing meds (medications), I saw resident #24 in the hallway going towards his room saying things to himself by the laundry. He's been irritable since he moved in. The other caregiver stepped out and then I started doing meds with my towards them. It wasn't until I heard hits flying I realized resident #24 was in the common area. I stopped doing meds and went to separate the two. I was trying to catch resident #25 as he was falling to the ground. I stayed in the middle of them and that is when Caregiver S returned. I didn't see resident #25 actually hit resident #24 in the , but he didn't have any knots before the incident. I called the nurse on duty, LPN K, paging him twice. I informed all parties of the incident, and then we would do our best to keep them away from each other. We moved resident #24 to the other side of the room in the dining area at the table so that I could watch him and we got resident #25 to sit down." On at 11:13 AM, the Director of Resident Care stated she was made aware of some type of altercation between resident #24 and #25. She said she called hospice for resident #24 and notified resident #25's family. She recalled they had changed resident #24's medication prior to this incident because of his aggression and his family had made them aware	A 025		

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A 025	Continued From page 70 that he had issues with male roommates in previous settings. The Director stated, "resident #24 has a male roommate and has not him. We notated his behaviors, agitation, and he's never shown any issues prior to that day. We really don't have a written plan in place. We just inform the staff to watch more and everyone is aware of that. Both residents have been in the same room since the incident and nothing more has happened. Resident #25 is more of a gentle giant and is more to defend himself if someone comes at him." On at 11:35 AM, in a telephone exit interview, the Vice President of Clinical Services and Compliance, Administrator, and Director of Resident Care confirmed the findings. (photographic evidence obtained) Class II	A 025		
A 030 SS=J	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	A 030		

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A 030	Continued From page 71 residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 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.	A 030		

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A 030	Continued From page 72 Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and 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	A 030		

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A 030	Continued From page 73 correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , 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.	A 030		

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A 030	Continued From page 74 (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (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	A 030		

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A 030	Continued From page 75 telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the 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	A 030		

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A 030	Continued From page 76 which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure residents in the secure memory care unit lived in a safe living environment, free from and failed to follow its resident and neglect policy for 5 of 18 sampled residents, (5, 14, 20, 24, 27). Findings: Review of the facility's policy on reporting resident , neglect, or , , revised , , indicated that any known or suspected incidents of , neglect, or , will be reported immediately. Injuries are to be photographed. Review of a facility incident report revealed that on at about 5:30 PM, a physical altercation occurred between resident #14 and Caregiver I that resulted in the resident being pushed to the ground. The resident sustained a bump on the of her . Review of resident #14's record revealed she had diagnosis of with agitation. On at 9:36 AM, resident #14 was seen laying in her bed, awake. When asked if a staff member shoved her, she replied, "I think so. I didn't get hurt." On at 12:15 PM, Caregiver I said that on at approximately 5:30 PM, she saw resident #14 on her and wiping the	A 030		

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A 030	Continued From page 77 dining room floor. This caused food on the floor to smear. Using a firm tone because she thought this would work best, she said she told the resident to get off the floor "now." According to Caregiver I, the resident was agitated prior to this. She recalled the resident got up, approached her and grabbed her and bent her . She said she attempted to remove the resident's from her own when they both on the floor causing the resident to hit her resulting in a bump. Review of video camera recording of the incident revealed resident #14 and Caregiver I were initially about 5 from each other in the dining room. The video did not have any volume. Both could be seen verbally engaging the other. The resident then approached the caregiver, and it looked like they locked . While still holding on to each other, the caregiver began to walk forward, and the resident walked backward and they both to the floor. The Caregiver immediately got up and within a few minutes the resident got herself up. Caregiver J was seen on the video standing at a medication cart in the dining room. She remained at the cart while Caregiver I and resident #14 exchanged words and when the physical altercation and occurred. When they , Caregiver J approached and addressed Caregiver I but neither caregiver tended to the resident when she was still on the floor. Once the resident was up, Caregiver J was seen touching the of the resident's . On at 1:13 PM, Licensed Practical Nurse (LPN) K spoke about the incident and said he was called to come to memory care unit. He said when he arrived, resident #14 was standing and was agitated. He calmed the resident down then took her to her room. He recalled Caregiver J told	A 030		

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A 030	Continued From page 78	A 030		

him the resident , and he needed to check her . He saw a bump on the of the resident's . He explained the resident was on hospice, so he notified them about the . He said the resident had hit her during the , and he felt she needed to be sent to the hospital to be assessed. He noted when Emergency Medical Services ( ) arrived, they determined the resident was stable. spoke with the resident's family member, who decided against sending her to the hospital. He said neither Caregiver I nor J initially told him about the altercation. He stated he noted Caregiver I was agitated towards the resident when he first entered the unit. He explained he became suspicious as Caregiver J appeared nervous. He indicated Caregiver I told him she and the resident pushed each other, then both . He stated the Maintenance Director was still in the facility, so he asked him for the video recording. He then told Caregiver I he was moving her to the Assisted Living side to finish her shift, but she left the facility. He noted the hospice nurse responded to the facility later that night, but the resident refused to be assessed.

On at 1:52 PM, Caregiver J spoke about the incident involving resident #14. She said she saw resident #14 on her and cleaning the floor. Caregiver I then told the resident to get off the floor. The resident began calling Caregiver I names and the two began arguing and the altercation became physical. She said she asked the resident to off when the resident grabbed Caregiver I. They began fighting then both on the floor. She stated she called for LPN K to come and assist. Caregiver J said she did not immediately tend to the resident when she because by the time she got to them, the resident was already up. She said she felt the

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A 030	Continued From page 79 bump on the resident's , and said to Caregiver I, "look what you did." She said she did not intervene prior to the physical altercation because she never thought it would escalate. She indicated she told LPN K immediately about the altercation. On at 3:10 PM, an attempt was made to look at resident #14's , but she would not allow the assessment. On at 9:10 AM, resident #14's family member said she learned of the altercation from Law Enforcement when they called her on at 4:44 PM. She explained no one from the facility informed her. She also learned of the resulting when , not facility staff, called her on at 7:56 PM, to ask if she wanted the resident to go to the hospital. On at 10:24 AM, LPN K confirmed the family member learned of resident #14's when called her. He said he did not call himself because he was figuring out what to do. On at 11:51 AM, the Director of Resident Care said she called resident #14's family to discuss the video recording on at about 1 PM and 5 PM but the family member did not answer. The Director of Resident Care said a picture of the bump on the resident's was not taken. On at 2:52 PM, the Director of Resident Care stated she did not tell resident #14's family member about the altercation when it occurred on . She recalled the Maintenance Director called her on the evening of after he viewed the camera footage and thought the resident may have been abused. He asked her to view the video recording but she told him she was in the middle of having dinner and	A 030		

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A 030	Continued From page 80 would not view it. She forwarded the video to the Vice President of Clinical Services and Compliance, who could not open it. The Director of Resident Care told the Maintenance Director that LPN K said it was a and that was what they were going to deal with. On at 10:13 AM, resident #14's family member said that any time the resident had a she had a setback due to the . Since the incident the resident seemed more , which the family member contributed to the resident hitting her . The family member said the resident's agitation was not unusual but the resident was more and said she was scared. They added that Hospice was now visiting every day. The family did not think it beneficial to have the resident seen by a Psychiatrist due to the . On at 9:15 AM, the Vice President of Clinical Services and Compliance said there were new allegations involving residents #5 and #20. On at 7 PM the Vice President and the Resident Care Director gave training on reporting because of the incident that involved resident #14. Following the training, Caregiver Q told the Resident Care Director that she witnessed Caregiver R punch resident #20 in his at 2:48 AM that morning. Upon watching video camera recording from that time frame, the Vice President said she saw only Caregiver P enter resident #20's room with Caregiver R. Caregiver Q was never seen entering the room as she had stated. He stated Caregiver P said she previously witnessed Caregiver R yell at and be rough with resident #5 but could not remember the dates of this incident. Review of resident #20's record revealed he had	A 030		

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A 030	Continued From page 81 diagnosis of . On at 9:32 AM, resident #20 was seen sitting in a wheelchair in the memory care dining room. He was using his to propel himself around. He was severely , had difficulty finding words and used nonsensical sentences when interviewed. He was unable to contribute any valid information to the event. Observation of his abdomen showed no visible injuries. Review of video recording from showed Caregiver R entered resident #20's room at about 2:10 AM. She could be heard yelling and cursing at the resident. Caregiver Q then entered the room at about 2:16 AM. Review of video recording revealed Caregiver R entered resident #20's room on at about 3:47 AM. She could be heard yelling and cursing at the resident. Caregiver P was then seen entering the room. On at 9:39 AM, the Maintenance Supervisor said the time was one hour off on the videos. For example, 2:47 AM would be 3:47 AM. On at 1:38 PM, resident #20's family member said facility staff informed her of the allegations on at 8:52 PM. She said she was contacted by Law Enforcement on at 9:55 PM about the allegation. She said she usually visited every day and noted the resident had not complained of anything. Review of resident #5's record revealed diagnosis of . On at 9:38 AM, resident #5 was seen sitting in a wheelchair in the TV room of memory care unit. She had difficulty finding words and those she did say were nonsensical. When asked if she'd been yelled at or harmed, she did not answer. When asked if she was afraid, she replied "no." On at 1:57 PM, resident #5's	A 030		

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	AL11965661	A. BUILDING: _____ B. WING _____	10/03/2025

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A 030	Continued From page 82 family member said facility staff informed him of the above allegation on . On at 11:32 AM, Caregiver P said that during the early morning hours of , she was not sure of the exact time, she witnessed caregiver R be rough with resident #20. Caregiver R yelled and cursed at the resident. She yelled at him to put his brief on. He was standing and struggled to do it himself. Caregiver P said she never witnessed Caregiver R hit resident #20, only that she was rough when helping the resident with care. Caregiver P then said she witnessed Caregiver R slap resident #5's and arm and yell at her on two separate occasions. Caregiver P could not recall the dates. Caregiver P said she witnessed those types of incidents involving Caregiver R since the end of . She said she had not reported what she saw to a Supervisor, Department of Children and Families (DCF,) or law enforcement because Caregiver R asked her not to snitch on her. Caregiver P said she told Caregiver R it was wrong to hit the residents. On at 12:15 PM, Caregiver Q said that on at 2:48 AM, not as she initially reported, she heard a commotion. She saw Caregiver R in resident #20's room. The resident was swinging at Caregiver R, who was bent over putting his brief on. Caregiver R then punched the resident twice in his . Caregiver Q told her that it was not necessary and said she would take care of the resident. The two Caregivers never spoke of the incident again. Caregiver Q then said she also witnessed Caregiver R be verbally aggressive towards other residents, including residents #24 and #27. On at 6:30 AM she and Caregiver R were in resident #27's room when Caregiver R yelled and cursed	A 030		

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A 030	Continued From page 83 at the resident, saying the resident could do more than she was. She could not recall the dates for resident #24. Caregiver Q never reported what she saw to a Supervisor, DCF, or law enforcement because she did not want Caregiver R to retaliate against her. Caregiver Q stated that Caregiver R would know it was her because they worked together. She said she was afraid she would lose her job if she reported Caregiver R. Review of resident #24's record revealed diagnosis of . On at 10:57 AM, resident #24 was seen sitting in a wheelchair in the memory care common area. He did not respond when asked if staff yelled at or hit him. Review of resident #27's record revealed a diagnosis of 's . On at 11:17 AM, resident #27 was seen sitting in a wheelchair in the memory care dining room. She said, "staff yells but I don't know their names." Regarding whether staff hit her she replied, "I'm only , I don't get hit." On at 9:26 AM, Caregiver R said the allegations against her were false and never happened. Review of personnel records revealed Caregiver P received training on the policy on , Caregiver Q on , and Caregiver R on . On at 11:35 AM, via phone exit, the Vice President of Clinical Services and Compliance, Administrator, and Director of Resident Care confirmed the findings. (photographic evidence obtained)	A 030		

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A 030	Continued From page 84 Class I	A 030		
A 034 SS=D	59A-36.007(9) ASSISTIVE DEVICES (9) ASSISTIVE DEVICES. Facilities are responsible for ensuring the safe usage of a resident's assistive devices. (a) The facility must have policies and procedures that include the requirements and methods for assessing the physical condition of assistive devices that may injure the resident and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device. (b) Documentation of each assistive device a resident uses must be included in the resident's record. (c) Direct care staff using assistive devices while rendering personal services to residents must know how to operate and utilize the equipment. (d) All assistive devices must be clean, in good repair, and free of hazards. (e) The facility must encourage and allow the resident to function with independence when using the assistive device. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to have documentation in the resident's record of a resident's assistive device, for 1 of 4 sampled residents, (#13). Findings: On at 11:10 AM, observation revealed resident #13 stood up from the table and began to walk in the common area. Caregiver F called	A 034		

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A 034	Continued From page 85 out to resident #13 stating, "wait let me get your walker." Resident #13 replied "I'm fine and continued to walk towards another table in the common area before sitting down. A few minutes later, at 11:12 AM, the resident confirmed she used a walker and that the walker folded up in the corner of the room was hers. Review of resident #13's record revealed a facility admission on , A (1823) health assessment form indicated a risk for , , need for assistance with ambulation, toileting, and transferring. Further review revealed no evidence resident #13 required the use of an assistive device. Review of resident #13's Service Plan Report dated , did not reveal the use of an assistive device. On at 1:37 PM, the Director of Resident Care stated resident #13 mostly used a walker but had a wheelchair when she moved in. Review of the facility's , policy for Assistive Devices and Equipment indicated devices and equipment that assist with resident mobility, safety, and independence were provided for the resident per physician order. These included, but were not limited to wheelchairs, , walkers and canes. The policy detailed that recommendations for the use of devices and equipment were based on the comprehensive assessment and were to be documented in the resident's plan of care. The facility failed to follow their assistive device and equipment policy by not documenting in the	A 034		

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A 034	Continued From page 86 resident's plan of care or obtaining a physician's order for the walker. On at 4:03 PM, the Vice President of Clinical Services and Compliance after review of the Service Plan Report confirmed the facility did not have a physician's orders and there was no documentation in the resident care plan for the walker. (photographic evidence obtained) Class III	A 034		