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
	AL11969771	A. BUILDING: _____ B. WING _____	09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A1 SENIOR LIVING	242 NE 42ND ST DEERFIELD BEACH, FL 33064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced Relicensure and Generator Monitoring survey was conducted on at A1 Senior Living. The facility had deficiencies identified at the time of the survey.	A 000		
A 078	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . 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	A 078		

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A 078	Continued From page 1 assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility ⌄ to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure staff had documented evidence of Communicable Status and negative ( ) examination on an annual basis, for 1 of 2 sampled staff (Administrator).	A 078		

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A 078	Continued From page 2 The findings included: Review of the personnel file for Staff A (Administrator) with a hire date of revealed Staff A did not have documented evidence of Communicable Status. Further review revealed her file did not have documentation of annual negative examination status and thereafter for the years 2022, 2023, 2024 and 2025. During an interview on at approximately 11:50 AM, the Administrator was informed of the findings. At this time, she acknowledged the findings. No additional documentation was provided. Class III	A 078		
A 083	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.	A 083		

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A 083	Continued From page 3 (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 record review and interview, the facility failed to ensure that 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, for one out of two sampled staff (Administrator). The findings included: Record review of Staff A (Administrator) file, who was hired , who stated she currently lives in the facility and has no other employees currently working in the facility. Her employee file was reviewed for evidence of and First Aid certification. At the time of review on , Staff A did not have a valid First Aid certification card in her file. Further reviewed showed, the and First Aid certification was issued on and had to be renewed by . On at approximately 11:00 AM, the Administrator was informed there must be at least 1 employee on each shift that holds a valid and First Aid certification card. She was asked to produce proof of compliance at this time. On at approximately 11:50 AM, the Administrator was informed of the absence of documentation showing that nobody in the facility held a valid and First Aid certification card, the administrator acknowledged the findings, and	A 083		

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A 083	Continued From page 4 no further documents were received at the time of the survey. Class III	A 083		
A 093	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	A 093		

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A 093	Continued From page 5 supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to 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	A 093		

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

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A 093	Continued From page 7 residents, the facility also failed keep 6 months' worth of menus that must be dated and planned. The findings include: Review of the facility's Dietary Standards and Menus revealed the following concerns. A) Observations on at 8:50 AM revealed no emergency food was located in the facility. During an interview on at approximately 8:50 AM, the Administrator stated that she had no emergency food or water available for use for the residents and staff . Confidential interview on at 11:48 AM, revealed that during a visit to the facility on , 3 individuals/residents (placed by the city's homeless program) were observed and interviewed in the facility. Additional observations of the facility revealed that 3 adults were residing at the facility. According to the Administrator these resident were placed her through the local city homeless program. The Administrator upon request didn't provide the names of these individuals. Interview with Administrator on at approximately 9:30 AM, the Administrator stated her last resident (Resident #1) was admitted , , and discharged on , , and the resident was discharged to a higher level of care. Disaster Menu dated , and valid through provided by registered dietician showed the following items were needed in the facility in case of an emergency. 1. DAY 1, BREAKFAST Assorted Fruit Juice (4	A 093		

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A 093	Continued From page 8 oz), Assorted Dry Cereal (cup), Milk (8 oz). LUNCH, Assorted Canned Meat Pasta (8 oz), Crackers (6), Mixed Vegetables (1 cup), Pudding (cup). SNACK, Applesauce (cup) or Juice (4 oz). DINNER, Chicken Noodle Soup (8 oz), Peanut Butter (4 T) & Jelly (1 T), Crackers (6),Carrots (cup) Or Vegetable Juice (4 oz). 2. DAY 2, BREAKFAST Assorted Fruit Juice (4 oz), Assorted Dry Cereal (cup), Milk (8 oz). Lunch, Beef Stew or Chicken & Dumplings (8 oz), Crackers (6), Carrots (1 cup),Pudding (cup). Snack, Applesauce (cup) or Juice (4 oz). Dinner, Vegetable Soup (8 oz), Tuna (3oz), Crackers (6), Green Beans (cup), Or Vegetable Juice(4 oz)., Pears (1/2cup) BEDTIME SNACK, Milk (8 oz) and Graham Crackers/Cookies (3). 3. DAY 3, Breakfast, Assorted Fruit Juice (4 oz), Assorted Dry Cereal (cup), Milk (8 oz). Lunch, Chili with Beef (8 oz), Crackers (6), Green Beans (1 cup), Pudding (cup). Snack, Pineapple (cup) or Juice (4 oz). Dinner, Cream of Mushroom Soup (8 oz), Canned Chicken or Canned Meat (3oz), Crackers (6), Mixed Vegetables (cup), Or Vegetable Juice (4 oz), Peaches (cup), Milk (8 oz) and Graham crackers/Cookies (3), Milk (8 oz) and Graham Crackers/Cookies (3) B) Review of the facility's menu revealed it expired on . During an interview with the Administrator, she revealed she hadn't renewed her menus with the dietician and neither were they posted. She stated she had no further documentation regarding the menus. Class III	A 093		

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A 160	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a , ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to Rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan,	A 160		

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A 160	Continued From page 10 with documentation of review and approval by the county emergency management agency, as described in Rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in Rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by Section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 59A-36.007, F.A.C. (j) All food service records required in Rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.435, F.S., and rule Chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions	A 160		

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A 160	Continued From page 11 and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.; (q) The facility's prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.; (w) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to maintain all required facility records and ensure they are readily available for agency review. The findings included: During an interview with the Administrator at 9 AM and 11 AM, the following information was requested. However, the Administrator was unable to provide the requested documentation for review as facility records were not organized or maintained in a manner easily accessible for review by the surveyor. 1) The facility's admission and Discharge log (listing the names of all residents, discharges,	A 160		

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A 160	Continued From page 12 etc.) 2) The facility's Department of Health inspections for 2024 3) The facility's documented resident elopement response drills for 2023 to current 4) The facility's policy on Physical 5) The facility's policy on Assistive Devices 6) The staffing schedule for the facility 7) The resident records of residents that have resided at the facility within the last year During an interview with the Administrator she stated she had a resident in , that stayed for only a few months. Further observations during the survey revealed 3 unknown individuals were residing at the facility. The names were not provided by the Administrator. Class III	A 160		
A 161	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the	A 161		

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A 161	Continued From page 13 employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by Rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section 429.174, F.S., and Rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity , to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by Rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on interview and record review, it was determined that, the facility failed to maintain	A 161		

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
	AL11969771	A. BUILDING: _____ B. WING _____	09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A1 SENIOR LIVING	242 NE 42ND ST DEERFIELD BEACH, FL 33064

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A 161	Continued From page 14 staffing files on-site and available for review, for 1 of 1 sampled staffInterview and record view the facility failed to maintain personel records readily available for agency inspection. The findings included: During an interview on at 09:30 AM with the Administrator, the personnel files were requested for review. At this time, the Administrator stated she did not have any staff records for review. She stated, that she is the only staff member for the facility. The Administrator was also unable to provide a staffing schedule upon request. During an interview on at approximately 11:00 AM, Administrator was informed of the findings mentioned above. She acknowledged the findings; no additional documentation was provided. Class III	A 161		

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ZZ830	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider	ZZ830		

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ZZ830	Continued From page 1 is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database	ZZ830		

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ZZ830	Continued From page 2 approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to timely submit their request for approval of the Comprehensive Emergency Management Plan (CEMP), to the local emergency management agency. The findings included: On a re-licensure survey was conducted at the facility. During an interview with the Administrator on at 9:43AM, she was informed to provide the facility's current CEMP approval letter. The Administrator stated the last approval CEMP letter dated . A request was made to provide all communications, receipts and/or submissions she had regarding their CEMP. A review of the facility's CEMP letter from the Local Emergency Management Division dated , revealed an approval plan through . No proof of subsequent resubmissions of the CEMP to the County was provided during the survey. On at 9:50 AM during an interview with the Administrator, she acknowledged the CEMP letter was expired. The facility had no proof of documentation for communication, receipts and/or submissions of the CEMP for review to the Local Emergency Management Division at the time of the survey. Class III	ZZ830		

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