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
	AL11967433	A. BUILDING: _____ B. WING _____	R 10/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & J QUALITY CARE, LLC	13231 SW 278 TERRACE HOMESTEAD, FL 33032

(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
{CZ813}	59A-35.090(3)(c), FAC Results of Screening & Notification In File 59A-35.090 Background Screening. (3) Results of Screening and Notification. (c) The eligibility results of employee screening and the signed Attestation referenced in subsection 59A-35.090(2), F.A.C., must be in the employee's personnel file, maintained by the provider. This Statute or Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to maintain in file the eligibility results of employees screening for the Administrator and Staff B (Caregiver) in their personnel files. The facility failed to maintain signed attestations for the Administrator and Staff B in their personnel files. Findings: Observation on at 6:44 AM the facility was closed and failed to notify the agency 30 days before discontinuing operations and did not surrender its license. A review of the Administrator's personnel file found no eligibility results of screening and a signed attestation. A review of Staff B's personnel file found no eligibility results of screening and a signed attestation. Interviewed on at 1:28 PM the Administrator acknowledged that there was no documentation in their records. Uncorrected Unclassified	{CZ813}		

AHCA Form 3020-0001

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

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CZ817	408.810( ) FS; 59A-35.100 FAC Minimum Licensure Requirement - Inform AHCA 408.810 Minimum licensure requirements.-In addition to the licensure requirements specified in this part, authorizing statutes, and applicable rules, each applicant and licensee must comply with the requirements of this section in order to obtain and maintain a license. (3) Unless otherwise specified in this part, authorizing statutes, or applicable rules, any information required to be reported to the agency must be submitted within 21 calendar days after the report period or effective date of the information, whichever is earlier, including, but not limited to, any change of: (a) Information contained in the most recent application for licensure. (b) Required insurance or bonds. (4) Whenever a licensee discontinues operation of a provider: (a) The licensee must inform the agency not less than 30 days prior to the discontinuance of operation and inform clients of such discontinuance as required by authorizing statutes. Immediately upon discontinuance of operation by a provider, the licensee shall surrender the license to the agency and the license shall be canceled. (b) The licensee shall remain responsible for retaining and appropriately distributing all records within the timeframes prescribed in authorizing statutes and applicable rules. In addition, the licensee or, in the event of or dissolution of a licensee, the estate or agent of the licensee shall: 1. Make arrangements to forward records for each client to one of the following, based upon the client's choice: the client or the client's legal	CZ817		

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CZ817	Continued From page 2	CZ817		

representative, the client's attending physician, or the health care provider where the client currently receives services; or
2. Cause a notice to be published in the newspaper of greatest general circulation in the county in which the provider was located that advises clients of the discontinuance of the provider operation. The notice must inform clients that they may obtain copies of their records and specify the name, address, and telephone number of the person from whom the copies of records may be obtained. The notice must appear at least once a week for 4 consecutive weeks.

59A-35.100 Minimum Licensure Requirements. Provider location. A licensee must maintain proper authority for operation of the provider at the address of record. If such authority is denied, revoked or otherwise terminated by the local zoning or code enforcement authority, the Agency may deny or revoke an application or license, or impose sanctions.

This Statute or Rule is not met as evidenced by:
Based on observation, record review and interview, the facility failed to inform the agency not less than 30 days prior to the discontinuation of operation. The facility failed to surrender the license to the agency.

Findings:

Observation on at 6:44 AM more than four minutes passed after the doorbell rang, which went unanswered.

Observation on at 7:53 AM when Owner arrived found the facility to have no residents (#1, 2, 3, 4, and 5).

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CZ817	Continued From page 3 Interviewed on at 6:48 AM after a phone call, the Administrator stated that the facility had been closed since . The Administrator stated that the Owner became ill and the husband and her decided to close the facility. The Administrator stated that the agency was notified through their consultant. The Administrator stated that the residents had been moved to other assisted living facilities and with family members. The Administrator stated that the information was posted on the door and that the agency staff should look for the notice. Interviewed on at 7:53 AM the Owner stated that the facility was closed. A review of the facility's records found no copy of a closure notification. A review of the admissions and discharge log showed the following residents were discharged on: Resident #1 Resident #2 Resident #3 Resident #4 Resident #5 Unclassified	CZ817		

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{A 055} SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times;	{A 055}		

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{A 055}	Continued From page 1 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the	{A 055}		

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{A 055}	Continued From page 2 resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure refrigerated medications are kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked. Findings: Observation on at 6:44 AM the facility was closed and failed to notify the agency 30 days before discontinuing operations and did not surrender its license. Observation on at 6:51 AM unlocked medications found in the refrigerator (, 0.005% solution , , . Photographic evidence obtained. Interviewed on at 1:28 PM the Administrator acknowledged that the medications were not locked. Uncorrected Class III	{A 055}		
{A 078} SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF.	{A 078}		

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{A 078}	Continued From page 3 (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 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,	{A 078}		

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{A 078}	Continued From page 4 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 observation, record review and interview, the facility failed to ensure the Administrator and Staff B (Caregiver) obtain documentation of a negative tuberculous on an annual basis. The facility failed to ensure Staff C (Caregiver) obtain elopement response training. The facility failed to ensure Staff B was able to demonstrate and the , , ( ) techniques and on a chocking victim consistent with their level of education, training, preparation, and experience. Findings: Observation on at 6:44 AM the facility	{A 078}		

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{A 078}	Continued From page 5 was closed and failed to notify the agency 30 days before discontinuing operations and did not surrender its license. 1) Observation on at 6:47 AM Staff B was alone with four residents (#1, 2, 3, and 4). Observation on at 7:55 AM the Administrator arrived at the facility. A review of the Administrator's personnel records found no updated negative tuberculous documentation on file. A review of Staff B's personnel records found no updated negative tuberculous documentation on file. 2) A review of Staff C's personnel records found no elopement training on file. Interviewed on at 4:32 PM Staff B stated that she worked there for 14 years. 3) Interviewed on at 12:50 PM when asked what she would do for an unresponsive resident, Staff B stated, "Unresponsive, I would try to give of I will call 911. I would give them three , and then you add them to that. The last class I took was online. If there was a resident choking, I would try to get the resident to bring up the food." A review of Staff B's personnel records showed	{A 078}		

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{A 078}	Continued From page 6 training dated . Interviewed on at 1:28 PM the Administrator acknowledged that there was no documentation, no elopement training and Staff B did not know . According to the American Association, "For healthcare providers and those trained: conventional using , and -to- breathing at a ratio of 30:2 , -to-breaths." In the event of an adult choking, the America Association offer the guidelines below: 1. If the person can speak, , or breathe, do not interfere. 2. If the person cannot speak, or breathe, give thrusts 3. To employ the [thrust], reach round the person's waist. Position on clenched fist above the navel and below the cage. Grasp your fist with your other . Pull the clenched fist sharply and directly backward and upward under the cage six to 10 times quickly. 4. In case of and , , thrusts. Uncorrected Class III	{A 078}		
{A 152} SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.;	{A 152}		

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{A 152}	Continued From page 7 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be This Statute or Rule is not met as evidenced by: Based on observation, and interview, the facility failed to ensure a safe and living environment, free of hazard for four out of four sampled residents (#1, 2, 3, and 4).	{A 152}		

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{A 152}	Continued From page 8 Findings: Observation on at 6:44 AM the facility was closed and failed to notify the agency 30 days before discontinuing operations and did not surrender its license. Observation on at 6:52 AM a sharp knife was left unattended and accessible to the residents. Observation on at 8:32 AM the knife remained in the kitchen but on the counter. Observation on at 8:32 AM Residents #3 and 4 entered the kitchen while knife remained on the counter. Interviewed on at 1:28 PM the Administrator acknowledge that the knife was left in the kitchen. Uncorrected Class III	{A 152}		
{A 161} SS=D	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.	{A 161}		

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{A 161}	Continued From page 9 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff 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	{A 161}		

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{A 161}	Continued From page 10 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the Administrator maintained, at minimum, a copy of the employment application, with references furnished. Findings: Observation on at 6:44 AM the facility was closed and failed to notify the agency 30 days before discontinuing operations and did not surrender its license. A record review of the Administrator's personnel records found no employment application with references. Interviewed on at 1:28 PM the Administrator acknowledged that there was no employment application on file. Uncorrected Class III	{A 161}		
{A 180} SS=D	59A-36.019(1) FAC Emergency Management (1) EMERGENCY PLAN COMPONENTS. Pursuant to Section 429.41, F.S., each facility must prepare a written comprehensive emergency management plan using "Minimum Emergency Management Planning Criteria for Assisted Living Facilities," AHCA Form 3180-5006, , , incorporated by reference and available at http://www.flrules.org/Gateway/reference.asp?No	{A 180}		

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{A 180}	Continued From page 11 =Ref-15964. The form is also available at: https://ahca.myflorida.com/MCHQ/Emergency_Activities/index.shtml. The emergency management plan must, at a minimum, address the following: (a) Provision for all hazards; (b) Provision for the care of residents remaining in the facility during an emergency, including pre-disaster or emergency preparation; protecting the facility; supplies; emergency power; food and water; staffing; and emergency equipment; (c) Provision for the care of residents who must be evacuated from the facility during an emergency including identification of such residents and transfer of resident records; evacuation transportation; sheltering arrangements; supplies; staffing; emergency equipment; and medications; (d) Provision for the care of additional residents who may be evacuated to the facility during an emergency including the identification of such residents, staffing, and supplies; (e) Identification of residents with 's or related , and residents with mobility limitations who may need specialized assistance either at the facility or in case of evacuation; (f) Identification of and coordination with the county emergency management agency; (g) Arrangement for post-disaster activities including responding to family inquiries, obtaining medical intervention for residents, transportation, and reporting to the county emergency management agency the number of residents who have been relocated, and the place of relocation; and, (h) The identification of staff responsible for implementing each part of the plan.	{A 180}		

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{A 180}	Continued From page 12 This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to maintain an emergency plan component in the event of an evacuation. The facility failed to maintain a mutual aid agreement signed and dated by both administrators of the receiving and transfer facilities. The facility failed to maintain an emergency power plan for its portable generator. Findings: Observation on at 6:44 AM the facility was closed and failed to notify the agency 30 days before discontinuing operations and did not surrender its license. A review of the facility records found no comprehensive emergency management power plan, and no emergency plan for the portable generator. Interviewed on at 1:28 PM, the Administrator stated that a plan was submitted but she never received the documents. The Administrator stated further that she submitted it, but the girl was supposed to give her a copy. The Administrator stated, "We made copies." Uncorrected Class III	{A 180}		
{A 182} SS=D	59A-36.019(3) FAC Emergency Mgmt - Plan Implementation (3) PLAN IMPLEMENTATION. (a) All staff must be trained in their duties and are responsible for implementing the emergency	{A 182}		

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{A 182}	Continued From page 13 management plan. New staff must be trained on the plan within 30 days of employment. (b) If telephone service is not available during an emergency, the facility must request assistance from local law enforcement or emergency management personnel in maintaining communication This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure Staff B (Caregiver) was capable in the implementation the emergency in the event of a power outage. Findings: Observation on at 6:44 AM the facility was closed and failed to notify the agency 30 days before discontinuing operations and did not surrender its license. Observation on at 7:11 AM Staff B was unable to start the generator. Interviewed on at 1:28 PM the Administrator stated that she showed Staff B on how to start the generator last week. A review of Staff B's personnel records showed Emergency Preparedness training on . The Nation Oceanic and Atmospheric Administration (NOAA) states: "The 2025 Alantice season started on and runs through , NOAA predicts a 30% chance of a near normal, A 60% chance of an above normal season, and a 10% chance of a below normal season in the Atlantic basin this year. Uncorrected	{A 182}		

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{A 182}	Continued From page 14 Class III	{A 182}		
{A 000}	Initial Comments A revisit survey was conducted at M & J Quality Care, LLC on . The provider had deficiencies at the time of the survey.	{A 000}		
{A 025} SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 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,	{A 025}		

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{A 025}	Continued From page 15 including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's 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, record review and interview, the facility failed to provide appropriate and personal supervision while on the premises, and awareness of the general health, safety, and physical and emotional wellbeing before Resident #1's . Findings: Observation on at 6:44 AM the facility was closed and failed to notify the agency 30 days before discontinuing operations and did not	{A 025}		

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{A 025}	Continued From page 16 surrender its license. Observation on at 7:24 AM found Resident #1 in a wheelchair. Observation on at 7:50 AM Resident #1 attempted to stand up from the wheelchair and against the wall and slid down to the ground. Observation on at 7:51 AM the Administrator rushed from out of the office to assist the resident while Staff B (Caregiver) was in the kitchen. A review of Resident #1's health assessment dated showed a diagnosis of , , facet , , Acute , Injury (AKI), bacteremia, , II, and 's . The activities of daily living showed Resident #1 needed assistance with ambulation, bathing, , self-care, toileting, transferring and supervision with eating. Interviewed on at 1:28 PM the Administrator did acknowledge that Resident #1 attempting to get out of the wheelchair. Uncorrected Class III	{A 025}		
{A 030} SS=D	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary	{A 030}		

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{A 030}	Continued From page 17	{A 030}		

provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C.
(b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint.
(c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents 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

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{A 030}	Continued From page 18 and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where 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.	{A 030}		

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{A 030}	Continued From page 19 (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as 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	{A 030}		

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{A 030}	Continued From page 20	{A 030}		

paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community.
(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with 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

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{A 030}	Continued From page 21	{A 030}		

advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.
(2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility 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,

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{A 030}	Continued From page 22 managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure three (#2, 3, and 4) out of four sampled residents be treated with consideration and respect and with due recognition of personal dignity, and privacy. Findings: Observation on at 6:44 AM the facility was closed and failed to notify the agency 30 days before discontinuing operations and did not surrender its license. 1) Observation on at 7:01 AM Staff B (Caregiver) was Resident #2 in # in the presence of Residents #3 and 4 without a privacy screen and the room door wide open. Interviewed on at 1:28 PM, the Administrator stated that there was a bathroom in the room where Staff B could do that.	{A 030}		

Agency for Health Care Administration

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{A 030}	Continued From page 23 2) Observation on at 7:22 AM found a clogged bathroom sink in # . Interviewed on at 1:28 PM the Administrator stated that the plumber was to come the day before to fix but he was here to fix it. Uncorrected Class III	{A 030}		
{A 031} SS=D	59A-36.007(6) FAC Resident Care - Third Party Services (6) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, , and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate	{A 031}		

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{A 031}	Continued From page 24	{A 031}		

with the provider to facilitate the receipt of care and services provided to meet the , resident's needs.
(c) The administrator or designee must ensure that:
1. Care coordination includes documented communications about the resident's condition and response to treatment or services ordered by the physician which may impact the resident's appropriateness for continued residency in the facility;
2. Communications occur at least once every 30 days and whenever there is a significant change in the resident's condition; and
3. If physician ordered treatments or services occur less often than once a month, communications must be conducted according to the ordered treatment or service schedule and whenever there is a significant change in the resident's condition.
4. When communication with the third party provider is unsuccessful, at least two attempts at communication on two separate days must be documented. Documentation must include the name of the person from the third party provider with whom contact was attempted, the method of communication, and the date and time of the attempts. This documentation must be included in the resident's record in accordance with the timeframes in subparagraphs 59A-36.007(6)(c)2. and 3.
(d) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents'

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{A 031}	Continued From page 25 record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to maintain an interdisciplinary plan and an updated plan of care for Resident #1 under hospice care about the resident's condition at least once every 30 days and whenever there is a significant change. Findings: Observation on at 6:44 AM the facility was closed and failed to notify the agency 30 days before discontinuing operations and did not surrender its license. Observation on /2025 at 6:57 AM Resident #1 was in her room seated on the bed. A review of Resident #1's hospice records found no interdisciplinary plan nor an updated plan of care. Interviewed on at 1:28 PM, the Administrator acknowledged that there was no plan on file. Uncorrected Class III	{A 031}		
{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.	{A 032}		

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{A 032}	Continued From page 26 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 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	{A 032}		

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{A 032}	Continued From page 27 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 observation, record review and interview, the facility failed to conduct elopement drills for a census of four residents twice per year. Findings: Observation on at 6:44 AM the facility was closed and failed to notify the agency 30 days before discontinuing operations and did not surrender its license. A record review of the facility records only found the last elopement drill was conducted in 2023. Interviewed on at 12:30 PM the Administrator stated, "We have not had any elopements. [That was why we have not done any since 2023]." A review of the facility's policy on elopement	{A 032}		

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{A 032}	Continued From page 28 states: "It is the policy of the [facility] to conduct an elopement drill twice a year." Uncorrected Class III	{A 032}		
{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 and record review, the facility failed to have policies and procedures that include the requirements and methods for assessing the physical conditions of assistive devices. The facility failed to maintain a care plan for Resident #1's assistive devices. The facility failed to the document in Resident #1's records each assistive device used.	{A 034}		

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{A 034}	Continued From page 29 Findings: Observation on at 6:44 AM the facility was closed and failed to notify the agency 30 days before discontinuing operations and did not surrender its license. Observation on at 8:07 AM the Administrator assisted Resident #1 while seat in the wheelchair. A review of Resident #1's records found no documented assistive device and care plan. Interviewed on at 1:28 PM the Administrator stated that she did not even know she needed a care plan. The Administrator further stated that she (Resident #1) used a shower chair too. Uncorrected Class III	{A 034}		
{A 036} SS=D	59A-36.007(10) CONTROL PROCEDURES (10) CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of . (a) The facility must implement a hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or , . hygiene may include the use of -based rubs, , handwash, or handwashing with soap and water. (b) Standard precautions must be used when	{A 036}		

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{A 036}	Continued From page 30 there is an , exposure to transmissible agents in , , , , , nonintact skin, and mucuous during the provision of personal services. Standard precautions include: hygiene, and dependent upon the exposure, use of gloves, gown, mask, , protection, or a shield. (c) The facility must clean and reusable medical equipment and communal assistive devices that have been designed for use by multiple residents before and after each use according to the manufacturer's recommendations. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure Staff B (Caregiver) provided care in a manner that reduces the risk of transmission of for four (#1, 2, 3, and 4) out of five residents. Findings: Observation on at 6:44 AM the facility was closed and failed to notify the agency 30 days before discontinuing operations and did not surrender its license. Observation on at 8:24 AM Staff B offered the medications to Resident #4; . 5 MG, and , 100 MG, but did not wash nor change gloves after medication pass. Observation on at 8:28 AM Staff B offered the medications to Resident #3; , 1 MG, Chewable C 1000 MG, , , but did not wash nor change gloves after medication passed.	{A 036}		

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{A 036}	Continued From page 31 Observation on at 8:30 AM Staff B offered the medications to Resident #1; , 81 MG, , 25 MG, Reno Capsule, and , 40 MG, but did not wash nor change gloves after medication pass. Observation on at 8:40 AM Staff B offered the medications to Resident #2; 5 MG, , 5 MG, % MG, SOD 25 MG, , 40 MG, Megestrol 40 MG, and , 20 MG to Resident #2, but did not wash nor change gloves after medication pass. Interviewed on at 1:28 PM the Administrator stated, "She is supposed to wash her and change her gloves." A review of Staff B's personnel records showed control training on . A review of the assistance with self-administration of medication policy states: "Wash with soap and water." Uncorrected Class III	{A 036}		
{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	{A 052}		

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{A 052}	Continued From page 32 dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit 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.	{A 052}		

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{A 052}	Continued From page 33 (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a , of the body. (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 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	{A 052}		

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{A 052}	Continued From page 34 procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 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	{A 052}		

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{A 052}	Continued From page 35 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure Staff B (Caregiver) orally advise Residents #1, 2, 3, and 4 of the name and dosage of their medications. Findings: Observation on at 6:44 AM the facility was closed and failed to notify the agency 30 days before discontinuing operations and did not surrender its license. Observation on at 8:24 AM Staff B offered the medications , 5 MG, and , 100 MG to Resident #4 without naming the medications and dosage. Observation on at 8:28 AM Staff B offered the medications , 1 MG, Chewable C 1000 MG, and , to Resident #3 without the naming the medications and dosage.	{A 052}		

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{A 052}	Continued From page 36 Observation on at 8:30 AM Staff B offered the medications , 81 MG, , 25 MG, Reno Capsule, and , 40 MG to Resident #1 without naming the medications and dosage. Observation on at 8:40 AM Staff B offered the medications 5 MG, , 5 MG, % MG, SOD 25 MG, , 40 MG, Megestrol 40 MG, and , 20 MG to Resident #2 without naming the medications and dosage. Interviewed on at 1:28 PM the Administrator acknowledged that the employee did not name the medications and dosage. Uncorrected Class III	{A 052}		
{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	{A 054}		

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{A 054}	Continued From page 37 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 observation, record review and interview, the facility failed to ensure Staff B (Caregiver) immediately update the medication observation record (MOR) after the medications were offered for three (#1, 2, and 3) out of five. Findings: Observation on at 6:44 AM the facility was closed and failed to notify the agency 30 days before discontinuing operations and did not surrender its license. Observation on at 8:28 AM Staff B offered the medications , 1 MG, Chewable C 1000 MG, , to Resident #3, but did not immediately update the MOR. Observation on at 8:30 AM Staff B offered the medications , 81 MG, , 25 MG, Reno Capsule, and , 40 MG to Resident #1, but did not	{A 054}		

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{A 054}	Continued From page 38 immediately update the MOR. Observation on at 8:40 AM Staff B offered the medications 5 MG, 5 MG, % MG, SOD 25 MG, 40 MG, Megestrol 40 MG, and 20 MG to Resident #2, but did not immediately update the MOR. Interviewed on at 1:28 PM the Administrator acknowledged that the MOR was not updated. A review of Staff B's personnel records showed assistance with self-administration of medication training for four hours dated A review of the assistance with self-administration of medication policy states: "sign MOR after each individual medication taken. Uncorrected Class III	{A 054}		
{A 081} SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation.	{A 081}		

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{A 081}	Continued From page 39 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 administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel	{A 081}		

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{A 081}	Continued From page 40 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 within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility.	{A 081}		

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{A 081}	Continued From page 41 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 observation, record review and interview, the facility failed to ensure the Administrator received one-hour of the control training. The facility failed to ensure the	{A 081}		

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{A 081}	Continued From page 42 Administrator, Staff B and C (Caregivers), received two hours of pre-service orientation training. Findings: Observation on at 6:44 AM the facility was closed and failed to notify the agency 30 days before discontinuing operations and did not surrender its license. A review of the Administrator's personnel records found no one hour of control nor two hours of pre-service orientation training. A review of Staff B and Staff C personnel records found no two-hour pre-service orientation training. Interviewed on at 1:28 PM, the Administrator acknowledged the training was not completed. Uncorrected Class III	{A 081}		
{A 093} SS=G	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	{A 093}		

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{A 093}	Continued From page 43 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 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	{A 093}		

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{A 093}	Continued From page 44	{A 093}		

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.
(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 .

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{A 093}	Continued From page 45 (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 follow a therapeutic diet prescribed by a primary care physician for Resident #2. The facility failed to obtain a license dietitian with an updated license. The facility failed to maintain regular and therapeutic menus as served, with substitutions noted before or when the meal was served were kept on file for six months. Findings: Observation on at 6:44 AM the facility was closed and failed to notify the agency 30 days before discontinuing operations and did not surrender its license. 1) Observation on at 8:19 AM Resident #2 was served a sandwich on whole bread, scrabble eggs with tomatoes, and chunked fruits. A review of Resident #2's records found a prescription dated showed a pureed diet and	{A 093}		

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{A 093}	Continued From page 46	{A 093}		

A review of Resident #2's health assessment dated showed , ( ). The medications instructions showed crushed medications.

The Mayo Clinic defines as: "a medical term for swallowing. can be a painful condition. In some cases, swallowing is impossible. Occasional difficulty swallowing, such as when you eat too fast or don't chew food well enough, usually isn't cause for concern. But ongoing can be a serious medical condition."
Rutgers Institute of New Jersey states: "A pureed diet is a regular food that is blended. Mashed or whipped to be smooth and free of lumps, just like pudding. Foods with nuts or seeds, and uncooked fruits and vegetables are not allowed on this diet."

2)

A review of the facility records found no six months menu and an expired dietitian license.

Interviewed on at 1:28 PM the Administrator stated that she only thought it was Resident #5 with a pureed diet." The Administrator stated further, "we have to correct that. I will call the doctor." The Administrator stated further that she should have the dietitian license.

Uncorrected
Class II