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
	AL11967992	A. BUILDING: _____ B. WING _____	11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENDALL ALF II, INC	10230 SW 91 STREET MIAMI, FL 33176

(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 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.; 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	A 152		

AHCA Form 3020-0001

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

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A 152	Continued From page 1 This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe living environment, free of hazards. Findings included: Observation on at 6:05am showed that the facility was completely dark. Observation on at 6:06am showed that when Staff B turned on the lights by the entrance of the facility there was a bed. The bed appeared messy as if someone was lying on it. Staff B was observed removing a phone from the bed. Observation on at 6:07am showed that by the kitchen near the dining room there was a room that lead into the laundry. Staff B was observed entering the room without a key. In the laundry there were unlocked chemicals. It the laundry room there was another room where staff slept and kept personal items. Staff B opened this door to the staff room without a key. Inside the staffroom across the doorway there was a 5-day pill organizers with medications. During an interview on at 6:07am Staff B stated that the pill organizer belonged to her. When asked if the rooms could be locked with a key to prevent a resident from opening the doors. Staff B demonstrated that the door had a lock on it. Observation on at 6:08am showed that that the door to the laundry had simple privacy lock that could be locked and unlocked from inside of the facility and did not require a key, code, or special knowledge to open.	A 152		

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A 152	Continued From page 2 Observation on at 6:19am showed that on the outside of the facility there were rusted metal sheets throughout the fenceline of the property, covering the emergency water and stack precariously on top of a propane tank. During an interview on at 6:20am Staff B stated that the rusted metal sheets were gifted to the facility and the sheets were put along the fenceline. Observation on at 6:20am showed there were three 5-gallon gasoline canisters kept unlocked under a tarp in the backyard. During an interview on at 6:50am Staff B stated that Resident # 3 and #4 can ambulated on their own. Class III	A 152		
A 160 SS=D	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	A 160		

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A 160	Continued From page 3 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, 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,	A 160		

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A 160	Continued From page 4 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 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.;	A 160		

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A 160	Continued From page 5 (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 interview and record review the facility failed to ensure that it maintained a admission and discharge log that included the discharged addresses and ensured its lability insurance policy was physically and readily available in the facility. Findings include: 1) During an interview on at 6:54AM, the Administrator stated that she could provide confirmation that the liability insurance had been paid, and she had not been able to print it out. During an interview on at 7:06AM, the Administrator showed that she had the liability insurance policy on her phone. During an interview on at 7:14AM, the Administrator stated that she would leave to get the liability insurance policy printed out. During an interview on at 9:35AM, the Administrator stated that she now had the liability insurance policy and provided the physical copy. A review of the facility's records revealed that the posted liability insurance policy was dated and expired . 2) During an interview on at 9:37AM, when	A 160		

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A 160	Continued From page 6 advised that the facility's admission and discharge log did not contain discharge addresses, the Administrator stated that it did. Upon being shown that it did not, the Administrator acknowledged the error. A review of the admission and discharge log revealed that it did not contain the addresses of where residents had been discharged to. Class III	A 160		
A 162 SS=F	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or	A 162		

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A 162	Continued From page 7 implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A ⌄ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their ⌄ recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that ⌄ not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly	A 162		

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A 162	Continued From page 8 written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be	A 162		

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A 162	Continued From page 9 provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided 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 observation, interview, and record review the facility failed to maintain accurate and up to date resident records for four out of four sampled residents (Resident #1, #2, #3, and #4) Findings included: 1) Observation on at 6:13am showed that Resident #1 was in bed. A hospice care nurse was with him. During an interview on at 6:13am Staff B stated that Resident #1 was bedridden, under hospice care, and was . During an interview on at 8:18am Staff B stated that only one Resident had a do-not order ( ). Staff B stated that Resident #1 had a , but after hospitalization it was lost. The facility has attempted to get another signed but the family has not signed a new one. Staff B believed that the family did not want to sign a . A review of Resident # 1's record showed that he did not have a order in the record nor was there any information that a order was revoked/rescinded by a healthcare surrogate.	A 162		

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A 162	Continued From page 10 2) Observation on at 6:15am showed that Resident #2 was sleeping in # . Resident #2 had half-bed rails installed on the upper portion of her bed. At the lower portion of her bed a chair was placed with its backside facing the portion of the bed without bed rails. A review of Resident 2's records showed that she had an order, consent, and plan for the use of half-bed rails, but did not have an order or consent for full- bed rails. Resident # 2's use plan did not mention the use of a chair. During an interview on at 8:18am Staff B elaborated that Resident # 2 scooted out of bed while she sleeps and that she worried that the resident could out of bed. 3) Observation on at 6:18am showed that Resident #3 was not in her room. During an interview on 6:50am Staff B stated that Resident # 3 was taken to the hospital after she went to a doctor's on . According to Staff B this was a post-surgery visit. Resident # 3 was apparently hospitalized from to because of her gall and . A review of Resident #3's records showed that the last entry in Resident # 3 progress note was . On Resident # 3 complained about "feeling weird" and went to the emergency room and had "gall problems and developed an ." There was no documentation of her hospitalization on	A 162		

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A 162	Continued From page 11 or . 4) Observation on at 6:19am showed that Resident #4 was not in her room. During an interview on 6:50 am Staff B stated that Resident # 4 was taken to the hospital a few days earlier after she complained of . Staff B stated that Resident # 4 retained fluid and this happened to her frequently. A review of Resident #4's records showed that the last entry in Resident # 4 progress notes was and there was no documentation of her recent hospitalization. Class III	A 162		
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 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, interview and record review, the facility failed to ensure that One of three sampled staff (Staff B)were trained in their duties and able to implement the emergency	A 182		

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A 182	Continued From page 12 management plan. Findings Included: Observation at 6:18am showed that there were 2 residents at the facility. Resident #1 was bedridden. Observation on at 6:20am showed there were three 5-gallon gasoline canisters, a propane tank, and a generator under a tarp in the backyard. Staff B attempted to start another generator kept under the backyard patio deck; it would not start. The generator was a 3100 watt device that ran on gasoline only. During an interview on at 6:20 am Staff B stated that the generator under the tarp was broken and the one that she attempted to start ran on gasoline only. When asked how long the generator would run with the fuel onsite, she stated that she did not know. During an interview on at 8:18am Staff B did not know where residents would be evacuated to in the event that the facility became uninhabitable after an emergency. During an interview on at 12:10pm Staff C did not know where residents would be evacuated to in the event of an emergency that would make the facility uninhabitable. She stated that the Administrator would know. A review of the facility last approved comprehensive emergency management plan showed that the facility had two mutual aid agreements where the facility can evacuated resident in an emergency event.	A 182		

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A 182	Continued From page 13 Class III	A 182		
A 200 SS=D	59A-36.025 FAC Emergency Environmental Control 59A-36.025 Emergency Environmental Control for Assisted Living Facilities. (1) DETAILED EMERGENCY ENVIRONMENTAL CONTROL PLAN. Each assisted living facility shall prepare a detailed plan ("plan") to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency environmental control in the event of the loss of primary electrical power in that assisted living facility which includes the following information: (a) The acquisition of a sufficient alternate power source such as a generator(s), maintained at the assisted living facility, to ensure that current licensees of assisted living facilities will be equipped to ensure air temperatures will be maintained at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. 1. The required temperature must be maintained in an area or areas, determined by the assisted living facility, of sufficient size to maintain residents safely at all times and that is appropriate for resident care needs and life safety requirements. For planning purposes, no less than twenty (20) net square per resident must be provided. The assisted living facility may use eighty percent (80%) of its licensed bed capacity as the number of residents to be used in the to determine the required square footage. This may include areas that are less than the entire assisted living facility if the assisted living facility's comprehensive emergency management plan includes allowing a resident to congregate when he or she desires in	A 200		

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	AL11967992	A. BUILDING: _____ B. WING _____	11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENDALL ALF II, INC	10230 SW 91 STREET MIAMI, FL 33176

(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 200	Continued From page 14	A 200		

portions of the building where temperatures will be maintained and includes procedures for monitoring residents for signs of heat related injury as required by this rule. This rule does not prohibit a facility from acting as a receiving provider for evacuees when the conditions stated in Section 408.821, F.S. and subsection 59A-36.019(5), F.A.C., are met. The plan shall include information regarding the area(s) within the assisted living facility where the required temperature will be maintained.
2. The alternate power source and fuel supply shall be located in an area(s) in accordance with local zoning and the Florida Building Code.
3. Each assisted living facility is unique in size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and staffing characteristics. Accordingly, this rule does not limit the types of systems or equipment that may be used to achieve temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. The plan shall include information regarding the systems and equipment that will be used by the assisted living facility and the fuel required to operate the systems and equipment.
a. An assisted living facility in an evacuation zone pursuant to Chapter 252, F, S. must maintain an alternative power source and fuel as required by this subsection at all times when the assisted living facility is occupied but is permitted to utilize a mobile generator(s) to enable portability if evacuation is necessary.
b. Assisted living facilities located on a single campus with other facilities under common ownership, may share fuel, alternative power resources, and resident space available on the

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A 200	Continued From page 15 campus if such resources are sufficient to support the requirements of each facility's residents, as specified in this rule. Details regarding how resources will be shared and any necessary movement of residents must be clearly described in the emergency power plan. c. A multistory facility, whose comprehensive emergency management plan is to move residents to a higher floor during a flood or surge event, must place its alternative power source and all necessary additional equipment so it can safely operate in a location protected from flooding or storm surge damage. (b) The acquisition of sufficient fuel, and safe maintenance of that fuel at the facility, to ensure that in the event of the loss of primary electrical power there is sufficient fuel available for the alternate power source to maintain temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours after the loss of primary electrical power during a declared state of emergency. The plan must include information regarding fuel source and fuel storage. 1. Facilities must store minimum amounts of fuel onsite as follows: a. A facility with a licensed capacity of 16 beds or less must store 48 hours of fuel onsite. b. A facility with a licensed capacity of 17 or more beds must store 72 hours of fuel onsite. 2. An assisted living facility located in an area in a declared state of emergency area pursuant to Section 252.36, F.S. that may impact primary power delivery must secure ninety-six (96) hours of fuel. The assisted living facility may utilize portable fuel storage containers for the remaining fuel necessary for ninety-six (96) hours during the period of a declared state of emergency. 3. Piped natural gas is an allowable fuel source	A 200		

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A 200	Continued From page 16 and meets the onsite fuel supply requirements under this rule. 4. If local ordinances or other regulations limit the amount of onsite fuel storage for the assisted living facility's location, then the assisted living facility must develop a plan that includes maximum onsite fuel storage allowable by the ordinance or regulation and a reliable method to obtain the maximum additional fuel at least 24 hours prior to depletion of onsite fuel. (c) The acquisition of services necessary to maintain, and test the equipment and its functions to ensure the safe and sufficient operation of the alternate power source maintained at the assisted living facility. (d) The acquisition and maintenance of a monoxide alarm. (2) SUBMISSION OF THE PLAN. (a) Each new assisted living facility shall submit the plan required under this rule prior to obtaining a license. (b) Each existing assisted living facility that undergoes any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of its systems or equipment affecting the facility's compliance with this rule shall amend its plan and submit it to the county emergency management agency for review and approval. (3) APPROVED PLANS. (a) Each assisted living facility must maintain a copy of its approved plan in a manner that makes the plan readily available at the licensee's physical address for review by a legally authorized entity. If the plan is maintained in an electronic format, assisted living facility staff must be readily available to access and produce the plan. For purposes of this section, "readily available" means the ability to immediately	A 200		

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produce the plan, either in electronic or paper format, upon request.
(b) Within 30 days of the approval of the plan from the county emergency management agency, the assisted living facility shall submit in writing proof of the approval to the Agency for Health Care Administration to assistedliving@ahca.myflorida.com.
(c) The assisted living facility shall submit a consumer-friendly summary of the emergency power plan to the Agency. The Agency shall post the summary and notice of the approval and implementation of the assisted living facility emergency power plans on its website within ten (10) business days of the plan's approval by the county emergency management agency and update within ten (10) business days of implementation.
(4) IMPLEMENTATION OF THE PLAN.
(a) Each assisted living facility licensed prior to the effective date of this rule shall, no later than . , have implemented the plan required under this rule.
(b) Each new assisted living facility shall implement the plan required under this rule prior to obtaining a license.
(c) Existing assisted living facilities that undergo any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of the systems or equipment affecting the assisted living facility's compliance with this rule shall implement its amended plan concurrent with any such additions, modifications, alterations, refurbishment, renovations or reconstruction.
(5) POLICIES AND PROCEDURES.
(a) Each assisted living facility shall develop and implement written policies and procedures to ensure that the assisted living facility can

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A 200	Continued From page 18 effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. The procedures shall ensure that residents do not experience complications from fluctuations in air temperatures inside the facility. Procedures must address the care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury including: 1. The use of cooling devices and equipment; 2. The use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration; 3. Wellness checks by assisted living facility staff to monitor for signs of , and heat injury; and 4. A provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy. (b) Each assisted living facility shall maintain the written policies and procedures in a manner that makes them readily available at the licensee's physical address for review by a legally authorized entity. If the policies and procedures are maintained in an electronic format, assisted living facility staff must be readily available to access the policies and procedures and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce the policies and procedures, either in electronic or paper format, upon request. (c) The written policies and procedures must be readily available for inspection by each resident; each resident's legal representative, designee, surrogate, guardian, attorney in fact, or case manager; each resident's estate; and such additional parties as authorized in writing or by	A 200		

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A 200	Continued From page 19 law. (6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this rule, the Agency for Health Care Administration may seek any remedy authorized by Chapter 429, Part I, or Chapter 408, Part II, F.S., including, but not limited to, license revocation, license suspension, and the imposition of administrative fines. (7) COMPREHENSIVE EMERGENCY MANAGEMENT PLAN. (a) Assisted living facilities whose comprehensive emergency management plan is to evacuate must comply with this rule. (b) Each facility whose plan has been approved shall submit the plan as an addendum with any future submissions for approval of its comprehensive emergency management plan. (8) NOTIFICATION. (a) Within five (5) business days, each assisted living facility must notify in writing, unless permission for electronic communication has been granted, each resident and the resident's legal representative: 1. Upon the initial submission of the plan to the county emergency management agency that the plan has been submitted for review and approval; 2. Upon final implementation of the plan by the assisted living facility. 3. Annual submissions and approvals of the plan do not require notification to residents or their legal representatives unless a significant modification as defined in Rule 59A-36.019, F.A.C., has been made to the plan. (b) Each assisted living facility must maintain a copy of each notification set forth in paragraph (a) above in a manner that makes each notification readily available at the licensee's physical address for review by a legally authorized entity. If	A 200		

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the notifications are maintained in an electronic format, facility staff must be readily available to access and produce the notifications. For purposes of this section, "readily available" means the ability to immediately produce the notifications, either in electronic or paper format, upon request.

This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to have a working generator and the amount of fuel required to implement the emergency environment control plan on site.

Findings included:

Observation at 6:18am showed that there were 2 residents at the facility. Resident #1 was bedridden.

Observation on at 6:20am showed there were three 5-gallon gasoline canisters, a propane tank, and a generator under a tarp in the backyard. Staff B attempted to start another generator kept under the backyard patio deck; it would not start. The generator had a maximum output of 3100 watts which would run on gasoline only. Staff B attempted to start it on various occasions, and it would not start.

During an interview on at 6:20 am Staff B stated that the generator under the tarp was broken.

A review of the manufacturer's specifications this generator will run for 11 hours on 4.8 gallons of fuel at 75% load (2,300 watts) for approximately 35 hours with the fuel on site.

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A 200	Continued From page 21 A review of the facility's emergency environmental control plan showed that the facility had a different model generator listed with an output of 6250 watts. The generator would run lights, refrigeration, life safety systems, spot coolers, and fans. A review of the facility's comprehensive emergency management plan showed that the plan was submitted but had not yet been approved. During an interview at 8:53am with the Administrator stated that these generators "can be temperamental." Observation on at 9:00am showed that an unknown person was observed working on the generator outside. Observation on at 9:20am showed that the Administrator and Staff B started that generator. During an interview on /025 at 9:22am the Administrator stated that they needed to put fuel in it and could not lift the fuel canister. When advised that during an emergency staff would need to be able to start the generator without outside assistance, the Administrator said yes. Class III	A 200		
A 000	Initial Comments A standard biennial survey with generator monitoring was conducted at Kendall ALF II, Inc on . Deficiencies were identified at the time of the survey.	A 000		

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A 033 SS=D	59A-36.007(8) PHYSICAL (8) PHYSICAL . Residents for whom a physician has prescribed a physical must have a written care plan for the use of the physical . The care plan must be developed within 14 days of the device being prescribed, and prior to use on the resident. (a) The care plan must specify: 1. The device prescribed for use; 2. The maximum amount of time the resident is to have the applied each day; and, 3. In what manner and frequency staff will monitor, observe, and report to the physician any injuries, increase in agitation, signs and symptoms of , , or decline in mobility or function related to the use of the prescribed . (b) Facility staff must ensure that the device is applied appropriately and safely. (c) The resident's physician must review the appropriateness of the continued use of the physical annually, and documentation of this review must be maintained in the resident's record. If the resident's ability to independently remove or avoid the device fluctuates, the device must be considered a physical and all requirements of this subsection apply. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to develop a written care plan for the use of by one out of four sampled residents (Resident # 2). Findings Included: Observation on at 6:15am showed that Resident #2 was sleeping in # . Resident #2 had half-bed rails installed on the upper portion of her bed. At the lower portion of	A 033		

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A 033	Continued From page 23 her bed a chair was placed with its backside facing the portion of the bed without bed rails. During an interview on at 6:16am Staff B stated that she placed the chair at the bottom of Resident # 2 bed, so the resident does not get out of bed. She further elaborated that the staff room was far away from the residents' rooms. A review of Resident 2's records showed that she had an order, consent, and plan for the use of half-bed rails, but did not have an order or consent for full- bed rails. Resident # 2's use plan did not mention the use of a chair. During an interview on at 8:18am Staff B elaborated that Resident # 2 scooted out of bed while she sleeps and that staff worried that the resident could out of bed. Class III	A 033		
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 there is an , exposure to transmissible	A 036		

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A 036	Continued From page 24 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, interview and record review the facility failed to ensure that staff implemented hygiene and standard precautions in accordance with their control policies and procedures for one out of four sampled residents (Resident #2). Findings include: Observations on from 7:36AM to 7:53AM revealed that Staff B (Caregiver) completed multiple tasks without replacing her gloves: 7:36AM: Staff B put on a pair of gloves and began to pour Resident #2's pureed cereal breakfast into a bowl. 7:39AM: Staff B unlocked the facility's medication cabinet and retrieved Resident #2's medications. 7:40AM: Staff B proceeded to prepare Resident 2's medication into the medication grinding device.	A 036		

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A 036	Continued From page 25 7:42AM: Staff B collected Resident #2's medication, unlocked the medication cabinet and placed them inside. 7:43AM: Staff B turned on the medication grinding device. She then rinsed a spoon and poured the crushed medication on top of the resident's pureed cereal breakfast. She proceeded to open a kitchen drawer and grabbed a brush to remove the medication residue. 7:44AM: Staff B pulled a chair in front of Resident #2 and spoon-fed the resident the pureed cereal. 7:50AM: Staff B opened the refrigerator door and pulled out an iced beverage for the residents. 7:51AM: Staff B caressed Resident #2's . 7:52AM: Staff B removed a boiled egg from the stove and proceeded to crack the egg. She placed the egg in a bowl, then grabbed a kitchen knife. 7:53AM: Staff B spoon-fed the resident the egg. During an interview on at 8:18AM, when asked how she implemented control, Staff B advised that she used masks and gloves. When asked how she spreading germs between care of the residents, she stated that the residents are usually distanced. A review of the facility's control procedures revealed that the facility had a written policy that stated gloves were required to be changed after contact with a resident, and care should be taken to not contaminate the environment with soiled gloves.	A 036		

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A 036	Continued From page 26 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 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.	A 052		

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A 052	Continued From page 27 (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , , converting, or , medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a , of the body. (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or , preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of 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	A 052		

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	AL11967992	A. BUILDING: _____ B. WING _____	11/04/2025

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A 052	Continued From page 28 administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the 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	A 052		

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A 052	Continued From page 29 medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that staff followed proper procedures for assistance with self-administration of medication for one for one out of four sampled residents (Resident #2). Findings include: An observation on at 7:40AM revealed that Staff B did not orally advise Resident #2 the medication name or dosage that were to be	A 052		

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A 052	Continued From page 30 administered. Staff B proceeded to sign off on the medication observation report that the medication was administered before the resident had taken her medication. During an interview on at 8:18AM, Staff B advised that she received training on assistance with self-administration of medication. A review of Resident #2's chart revealed that there was not a signed written waiver that the resident had chosen not to be orally advised of the medication name and dosage and she required assistance with self-administration of medication. A review of Staff B's employee chart revealed that she had completed two hours of continued education training for assistance with self-administration of medication dated Class III	A 052		
A 053 SS=G	59A-36.008(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION. (a) For facilities that provide medication administration, a staff member licensed to administer medications must be available to administer medications in accordance with a health care provider's order or prescription label. (b) Unusual reactions to the medication or a significant change in the resident's health or behavior that may be caused by the medication must be documented in the resident's record and reported immediately to the resident's health care provider. The contact with the health care provider must also be documented in the	A 053		

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A 053	Continued From page 31 resident's record. (c) Medication administration includes conducting any examination or other procedure necessary for the proper administration of medication that the resident cannot conduct personally and that can be performed by licensed staff. (d) A facility that performs clinical laboratory tests for residents, including ␣ testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Chapter 483, Part I, F.S. A valid copy of the federal CLIA Certificate must be maintained in the facility. A federal CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a federal CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents' equipment. Information about the federal CLIA Certificate is available from the Laboratory and In-Home Services Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)412-4500. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that licensed staff were available to administer medication for one for one out of four sampled residents (Resident #2). Findings include: An observation on at 7:44AM revealed that Staff B spoon-fed Resident #2's crushed medication that was placed on top of the resident's pureed breakfast cereal.	A 053		

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A 053	Continued From page 32 During an interview on at 7:49AM, the Administrator confirmed that Staff B was unlicensed. She stated that she knew an unlicensed professional could not administer medication but was under the impression that the staff could put Resident #2's medication in her breakfast. During an interview on at 8:18AM, Staff B confirmed that Resident #2 is the only resident she spoon-fed medication to. During an interview on at 12:10PM, Staff C confirmed that she spoon-fed Resident #2 her medication. A review of Resident #2's chart revealed that the resident had an order for crushed medication dated and she required assistance with self-administration of medication. A review of Staff B's employee chart revealed that she was unlicensed and had completed two hours of continued education training for assistance with self-administration of medication dated . Class II	A 053		
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.	A 055		

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A 055	Continued From page 33 Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked;	A 055		

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A 055	Continued From page 34 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C.	A 055		

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A 055	Continued From page 35 This Statute or Rule is not met as evidenced by: Based on observation and interview the facility failed to maintain and secure centrally stored medications for one out of four sampled residents (Resident #1). Findings include: An observation on at 6:04AM revealed that Staff B placed Resident #1's medication on the kitchen table and left it unattended after she walked away. An observation on at 6:07AM revealed that Resident #1's medication was left unattended on an overbed table with no staff in the room. During an interview on at 9:37AM, when informed of medication left unattended the Administrator acknowledged the issue and stated that she would talk to the staff so it would not happen again. Class III	A 055		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information	A 056		

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A 056	Continued From page 36 must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication	A 056		

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A 056	Continued From page 37 observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to obtain a change in directions for medication that it provided assistance with self-administration for one out of	A 056		

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A 056	Continued From page 38 four sampled residents (Resident #2). Findings include: An observation on at 7:44AM revealed that Staff B spoon-fed Resident #2's pureed cereal along with her crushed medication of 5MG, 75MG, 20MG, 25MG, ER 20MEQ, and 5MG. During an interview on at 6:30AM, Staff B stated that she planned to provide Resident #2's breakfast along with her medication. A review of Resident #2's medication observation report revealed that Resident had an order to receive her 5MG, twice a day two hours after meals. A review of Resident #2's chart did not show that the facility obtained or had on file a change in directions for the 5MG. Class III	A 056		