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
	AL11968979	A. BUILDING: _____ B. WING _____	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACH HOUSE NAPLES ASSISTED LIVING & MEMOF	1000 AIRPORT PULLING RD S NAPLES, FL 34104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An emergency power plan monitoring and complaint investigation #2025006293, #2025016499, and #2025016799 was conducted at Beach House Naples Assisted Living & Memory Care on . Deficiencies were identified at the time of survey.	A 000		
A 025 SS=H	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 1 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, and interview, the facility failed to supervise residents to prevent elopement for 1 (Resident #3) of 14 memory care residents when the doors of the Memory Care Unit were not alarming. Failure to provide supervision lead to an elopement situation, a direct threat to Resident #3 who undetected out of the facility. The findings included: 1. On , at 2:45 p.m., during an interview,	A 025		

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A 025	Continued From page 2 the family member of Resident #3 said that he was in the facility to discuss Resident #3's return to the Memory Care unit. He said Resident #3 eloped on Saturday night and wanted to make the sure the doors were working correctly before he brought him . On , during record review, it was revealed that on at 6:50 p.m., Resident #3 eloped into the parking lot near the Memory Care door. On at 3:15 p.m., during an interview, Licensed Practical Nurse (LPN) Staff E verified Resident #3 eloped from the Memory Care Unit, found in the parking lot and brought into the building, then sent out. 2. On at 5:25 a.m., during a tour of the Memory Care unit, it was observed that 2 of the 3 exterior doors were blocked with chairs and furniture. One of the doors was a dedicated exit door to the exterior of the building and the other door led to separate corridors. ** Photographic Evidence Obtained ** On at 5:45 a.m., during an interview, Caregiver Staff B said that they piled up the furniture in the front of the 2 doors because the locks broke and they are concerned someone might get out if everyone is busy. It has been piled up since she got there late Saturday. On at 5:50 a.m., during an interview, Caregiver Staff C said they have a float person from the Assisted Living side that is helping them watch the doors but they put the furniture up to the door. She said that if there was an	A 025		

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A 025	Continued From page 3 emergency they can move the furniture or go out another door. She said that she knows she shouldn't do it but she has to if the alarms don't work because there is no one else here at night. On at 6:10 a.m., during an interview, Medication Technician Staff D said the door alarms were broken Saturday. She said that they shouldn't the exit doors, but they need to fix the alarms. On at 10:10 a.m., during an interview and Memory Care tour, the Director of Maintenance (DOM) said that the alarm to the Exit door works but the door to the maintenance corridor is currently not working. He said that the Medication Technicians or some staff have keys to the door alarms and can shut them off. The DOM said he doesn't know why that is the case. He had never heard of that before. He said each time he came by over the weekend he removed the furniture and told the staff to stop, and that there supposedly was an additional staff member added to just watch the doors this weekend. The DOM demonstrated the alarm and the lock on the Exit door and it was observed to be operational. The Director of Maintenance said that blocking the exit doors is a serious problem and a safety hazard. On at 12:00 p.m., during a tour of the Memory Care unit, the surveyor opened the door leading to maintenance hallway. The door was not alarmed. The door was not locked. There was direct access from the unlocked Memory Care door through a short corridor of about 20 to the left, to an additional unalarmed, unlocked door to the exterior of the building. The other direction heads to maintenance offices and the door of the kitchen. There were no staff	A 025		

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A 025	Continued From page 4 members observed to be watching the door. On at 3:42 p.m., during a Memory Care Unit tour, the Regional Director, the Executive Director and the Director of Maintenance team acknowledged that the door to the corridor and the outside of the building was not alarmed, or locked, and residents had access to the outside. They also observed that there were no staff members actively monitoring the door with Memory Care residents observed ambulating near the door. The Regional Director acknowledged that they need to do something to ensure resident safety. Class II .	A 025		
A 081 SS=E	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee ' s personnel record. (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	A 081		

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A 081	Continued From page 5 under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered	A 081		

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A 081	Continued From page 6 by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides	A 081		

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A 081	Continued From page 7 trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure all direct care staff complete a 1 hour in-service training covering Recognizing and Reporting Resident , Neglect, and , for 2 (Staff C, Staff J) out of 10 records reviewed. The findings included: On , during record review, it was	A 081		

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A 081	Continued From page 8 revealed that Caregiver Staff C had a hire date of . Staff C's employee file contained no documentation of completing the 1-hour training for , Neglect, and , . On , during record review, it was revealed that Caregiver Staff J had a hire date of . Staff J's employee file contained no documentation of completing the 1-hour training for , Neglect, and , . On at 12:20 p.m., during an interview, the Regional Director said that anyone who hasn't completed the training will be taken off the schedule until the training is done. The Regional ED acknowledged that this was against regulation. Class III .	A 081		
A 152 SS=H	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	A 152		

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A 152	Continued From page 9 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 that the physical plant was maintained free of hazards, and all existing architectural, mechanical, electrical, and structural systems are maintained in good working order. Failure to maintain a safe environment lead to an elopement situation and could provides a dangerous and unsafe living environment in the case of an emergency. The findings included: On at 5:25 a.m., during a tour of the	A 152		

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A 152	Continued From page 10 Memory Care unit, it was observed that 2 of the 3 exterior doors were blocked with chairs and furniture. One of the doors was a dedicated exit door to the exterior of the building and the other door led to separate corridors. ** Photographic Evidence Obtained ** On at 5:45 a.m., during an interview, Caregiver Staff B said that they piled up the furniture in the front of the 2 doors because the locks broke and they are concerned someone might get out if everyone is busy. It has been piled up since she got there late Saturday. On at 5:50 a.m., during an interview, Caregiver Staff C said they have a float person from the Assisted Living side that is helping them watch the doors but they put the furniture up to the door. She said that if there was an emergency they can move the furniture or go out another door. She said that she knows she shouldn't do it but she has to if the alarms don't work because there is no one else here at night. On at 6:10 a.m., during an interview, Medication Technician Staff D said the door alarms were broken Saturday. She said that they shouldn't the exit doors, but they need to fix the alarms. On at 7:55 a.m., during an interview, the Executive Director (ED)said she was not sure about the situation with the furniture and would confer with the Director of Maintenance. On at 10:10 a.m., during an interview and Memory Care tour, the Director of Maintenance (DOM) said that the alarm to the Exit door works but the door to the maintenance	A 152		

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A 152	Continued From page 11 corridor is currently not working. He said that the Medication Technicians or some staff have keys to the door alarms and can shut them off. The DOM said he doesn't know why that is the case. He had never heard of that before. He said each time he came by over the weekend he removed the furniture and told the staff to stop, and that there supposedly was an additional staff member added to just watch the doors this weekend. The DOM demonstrated the alarm and the lock on the Exit door and it was observed to be operational. The Director of Maintenance said that blocking the exit doors is a serious problem and a safety hazard. On at 12:00 p.m., during a tour of the Memory Care unit, the surveyor opened the door leading to maintenance hallway. The door was not alarmed. The door was not locked. There was direct access from the unlocked Memory Care door through a short corridor of about 20 to the left, to an additional unalarmed, unlocked door to the exterior of the building. The other direction heads to maintenance offices and the door of the kitchen. There were no staff members observed to be watching the door. On at 2:10 p.m., during an interview, Licensed Practical Nurse (LPN) Staff E said she can't understand why if there's an issue with the door, you can't get someone out to fix it right away, even the same day, because that is a problem. She said she's not sure whose idea it was to the doors with furniture, but that's not a solution either and it just creates more problems and safety hazards. On , at 2:45 p.m., during an interview, the family member of Resident #3 said that he was in the facility to discuss Resident #3's return	A 152		

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A 152	Continued From page 12 to the Memory Care unit. He said Resident #3 eloped on Saturday night and wanted to make the sure the doors were working correctly before he brought him . On , during record review, it was revealed that on at 6:50 p.m., Resident #3 eloped into the parking lot near the Memory Care door. On at 3:15 p.m., during an interview, Licensed Practical Nurse (LPN) Staff E verified Resident #3 eloped from the Memory Care Unit, found in the parking lot and brought into the building, then sent out. On at 3:30 p.m., during a Memory Care Unit tour, the DOM and the Regional Director said that the issue is that they are trying to retrieve the keys to the alarms because they could be turned off. The ED said that they told the staff on Saturday when the issue was brought to their attention not to the door as it was a safety hazard. The Executive Director (ED) said that we need to get all of the keys and change the manual lock on the alarm. The ED said that an extra staff member was added to watch the door at all times. She had no idea why they kept blocking the door. The ED said that an elopement occurred on Saturday night. On at 3:42 p.m., during a Memory Care Unit tour, the Regional Director, the Executive Director and the Director of Maintenance team acknowledged that the door to the corridor and the outside of the building was not alarmed, or locked, and residents had access to the outside. They also observed that there were no staff members actively monitoring the door with Memory Care residents observed ambulating	A 152		

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A 152	Continued From page 13 near the door. The Regional Director acknowledged that they need to do something to ensure resident safety. Class II .	A 152		