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
	AL11911669	A. BUILDING: _____ B. WING _____	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD VILLAGE RETIREMENT COMMUNITY	7830 PINE FOREST ROAD PENSACOLA, FL 32526

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A 000	Initial Comments An unannounced complaint survey for allegations contained in complaint numbers #2025011344 and #2025011345 was conducted at Homestead Village Retirement Community in Pensacola, FL from - . At the time of the survey, deficient practice was identified.	A 000		
A 030 SS=G	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow 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	A 030		

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A 030	Continued From page 1	A 030		

proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and , ;
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and standard precautions;
8. The requirements for coordinating the delivery of services to residents by third party providers;
9. Assistive devices; and
10. Physical .
(e) Residents may not be required to perform any work in the facility without compensation. 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

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A 030	Continued From page 2 telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened 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	A 030		

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facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a room with his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community.
(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

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A 030	Continued From page 4 Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free 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	A 030		

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A 030	Continued From page 5 exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that 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 interviews, observations, policy reviews, and record reviews, the facility failed to ensure residents' rights to be free from for 1 of 6 residents sampled for (Resident #1), and to be treated with dignity and respect, with consideration of the need for privacy for 6 of 6 residents residing in building J (Residents #1, #2, #8, #9, #10, and #11). The findings included:	A 030		

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A 030	Continued From page 6 Interviews were conducted on with facility staff and on with a hospice nurse who provided care to Resident #1 on . The interviews provided the following details: An incident involving Resident #1, a adult with a diagnosis of , occurred on at approximately 7:00pm which resulted in Resident #1 falling to the floor and hitting his . As a result of this , a hospice nurse was called to the facility to assess Resident #1 who was noted to have a small knot and small on his . The alleged incident involved Staff member A either intentionally or accidentally, causing Resident #1 to and hit his . Statements provided in interviews with Staff members A, B, and C, who were all present when the occurred, agreed that Resident #1 was standing over and touching Staff member A, trying to grab a pair of glasses that did not belong to Resident #1. Staff A, who was seated at a table in the common area of building K, was holding the glasses away from Resident #1 who reached around her from behind. Staff A stood up while Resident #1 was reaching around or over her and either the act of standing up or an intentional shove caused Resident #1 to and hit his on the floor. The interviews confirm that Staff member A was familiar with Resident #1 and aware that Resident #1 was a resident with a history of . After Resident #1 , Staff member C, who was the supervisor on duty, called an off-duty supervisor, Staff member I, to ask for guidance. Staff member I instructed Staff member C to send Staff member A home because Staff member B who witnessed the incident expressed that the resulted from an intentional "shove" by Staff member A. Staff member C sent Staff member A home. These events took place between 7:00pm and 9pm. At approximately	A 030		

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A 030	Continued From page 7 9:00pm, a hospice nurse arrived to assess and provide care to Resident #1. During this time, Staff members B and C were present. At some time after 10:00pm, Staff member B left, and Staff member C called the off-duty supervisor and was advised to call Staff member A to come to work. Staff members A and C both confirmed that Staff member A returned to the facility to provide care and worked the rest of the night shift on the night of through the morning of , when the day shift arrived between 6am and 7am. Staff member A was interviewed on at 4:30pm. Staff member B was interviewed on at 4:00pm. Staff member C was interviewed on at 4:46pm. Staff member I was interviewed on at 5:25pm. The hospice nurse was interviewed by phone on at 2:25pm. A record review for Resident #1 included a form 1823 dated and indicated the resident is an elopement risk, needs assistance with ambulation, bathing, , eating, self-care (grooming), toileting, and transferring, had a ground with , and special precautions of " risk" and "." Residents #1, #2, #8, #9, #10, and #11 reside in building J of the facility which is considered to be a "memory care" unit according to an interview with staff member B on at 4:00pm, who added that the residents' behaviors include , and they spend most of their time in the common area of the building. Staff member B said the air conditioning in the common area of building J had been out for at least five weeks and the residents of building J were moved and forth from building J to building K.	A 030		

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A 030	Continued From page 8 On at approximately 11:15am, an observation of building J was made, and no residents were inside the building. The assistant director of nursing (ADON) was in the building and said the residents were across the "street" (by which she was indicating a wide walkway, not a city street) at building K. When asked why the residents were in building K, the ADON explained they were working on the air conditioning. Standing fans were observed in the room and were on. A temperature taken near one of the fans in the common area showed that the air temperature was 82.7 degrees Fahrenheit. On at approximately 11:45 am, Residents #1, #2, #8, #9, #10, and #11 were observed in the common area of building K. During an interview on at 12:10pm, Staff member H said the six residents from building J slept in recliners in the common area of building K on the night of and said "this was not the first time" the residents slept in recliners in building K because of the uncomfortable temperatures in the common area of building J. During an interview on at 4:46pm, Staff member C confirmed Residents #1, #2, #8, #9, #10, and #11 from building J slept in the common area of building K in recliners on the night of . A review of the policy titled "Reporting , Neglect or , . . " effective , included a definition of , , as "Any willful act directed at a resident that is intended to result in or that is likely to result in injury or , . , includes slapping, pinching, kicking, shoving, and corporal punishment of any kind" and a definition of mental as "Any willful act directed at a resident that is intended to result in or that is likely to result in mental distress or mental anguish. It includes humiliation,	A 030		

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A 030	Continued From page 9 harassment, threats of punishment, and threats of deprivation." The policy included the following language as their procedure regarding , neglect, or , : 1. Any employee who witnesses what they believe may be an incident of , neglect or , must contact their supervisor immediately. 2. The Supervisor will immediately remove the resident from harm's way and 3. The accused will immediately be removed from duty by the Supervisor pending further investigation. 4. The Supervisor will then contact the Executive Director or designee as soon as possible. 5. If the incident should involve a shift supervisor or a Nurse, the reporter should contact the Executive Director at (phone number included) immediately. 6. The Executive Director will conduct an in-depth investigation of the incident. The person who observed the incident will write a complete report. This should include the name of the resident, what happened, where it happened, the time and date of the incident, and any possible witnesses to the incident. 7. The Executive Director will do a complete investigation. If, after the investigation, the accusation is deemed a reportable offense, the Department of Children and Families (DCF) registry will be notified at 1-800-96ABUSE OR 1-800-962-2873 and the employee will be terminated. 8. If the Executive Director cannot be reached within two hours, the Supervisor or reporter should call the hotline at 1-800-962-2873 to report the incident. 9. The Resident Care Supervisor will monitor the resident for any special needs or distress after the incident. The facility shall ensure that all staff	A 030		

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A 030	Continued From page 10 can demonstrate an understanding of what constitutes , neglect, and , and shall ensure that all staff understands their responsibility to immediately report suspected incidents of , neglect, or , of a resident to the Executive Director or designee When , neglect, or , is alleged or suspected, the facility shall conduct and document a thorough investigation and take appropriate action to prevent further . Class II	A 030		
A 152 SS=I	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,	A 152		

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A 152	Continued From page 11 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 observations, interviews, document and record reviews, the facility failed to maintain safe temperatures in the common and dining areas for all residents in buildings J, F and C, affecting 32 residents out of 32 residents. Additionally, the facility failed to provide access to a comfortable bed with a mattress and access to personal belongings for all residents in building J, who were moved to another building with functioning air conditioning and not provided rooms or beds to sleep in, affecting 6 out 6 residents (Residents #1, #2, #8, #9, #10, and #11). Findings include: On , temperature observations were recorded in Memory Care building J as follows: Time: 11:15 AM, Location: building J, common area, Temp: 82.5 Fahrenheit, (Humidity 58.9%) Time: 1:15 PM, Location: building J, common area, Temp: 83.4 Fahrenheit Additionally, it was noted that all blinds were closed, and three stand-up fans were operating in	A 152		

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A 152	Continued From page 12 the common area (Photographic evidence obtained). There were no residents in building J at the time of the observation. On , at approximately 1:41 PM, a temperature observation was recorded in the kitchen/dining area between assisted living building E and F as follows: Time: 1:41 PM, Location: Kitchen/Dining between building E&F, Temp: 83.4 Fahrenheit (Photographic evidence obtained). There were no residents in Kitchen/Dining between building E&F at the time of the observation. On during observations in building F, an interview was conducted with Staff K, in building F. She reported the AC had not been functioning for about 5 months and administration was aware of the problem and said they were going to fix it, but they need approval from corporate. She confirmed the dining room was hot as well. She pointed to an air mover fan placed on the floor next to the table in the living room to help circulate the air and keep it cooler. She was wearing a portable mini fan around her . She confirmed the elevated temperatures affected the residents who stayed in their rooms where the AC was working because it was too hot in the common area and did not socialize with each other because of the situation. Residents #5 and #6 were sitting on the couch in building F watching television in the common area. Both residents were interviewed at that time and said they were uncomfortable and that most residents stayed in their rooms and did not come out to socialize due to the heat and the AC not working in the common area and dining. On , temperature observations were recorded in assisted living building F as follows:	A 152		

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HOMESTEAD VILLAGE RETIREMENT COMMUNITY	7830 PINE FOREST ROAD PENSACOLA, FL 32526

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A 152	Continued From page 13 Time: 1:44 PM, Location: building F, common area/Table area, Temp: 84.9 Fahrenheit Time: 1:47 PM, Location: building F, common area/TV room area, Temp: 82.7 Fahrenheit Additionally, it was noted 1 fan was located by the entrance, and 1 air mover fan in living room (Photographic evidence obtained). On , at approximately 2:00 PM, a temperature observation was recorded in assisted living building C as follows: Time: 2:00 PM, Location: building C, common area/table area, Temp: 82 F/87.8 F Additionally, it was noted 1 fan in the common area (Photographic evidence obtained). On at approximately 2:02 PM, an interview was conducted with Staff L., /Medication Technician in building C. She reported the AC had not been functioning for the past 2 weeks in the common area and that all the residents were in their rooms because they were too hot in the common area. On at approximately 4:00PM, a phone interview was conducted with Staff B, personal care assistant ( ). She explained that she brought all 6 residents from building J to building K last night ( ) because the AC was not working. She explained all the residents have and are in memory care and added it was 115-degree Fahrenheit in the middle of the day in building J. She further indicated it was her judgment call to move the residents from building J to building K, and she was informed it was wrong to do that because the facility didn't want the residents to go over to building K. She said they had been moved and forth several times because the AC was not working and she did it for safety reasons. She explained the AC has been out since she started her employment	A 152		

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A 152	Continued From page 14 at the end of and heard from co-workers that the situation has been going on for about 6 months. On at approximately 11:15 AM, an interview was conducted with the assistant director of nursing (ADON). She explained the residents from building J go across to building K due to the air conditioning being out in building J common areas. On at approximately 11:15 AM, an interview was conducted with the maintenance director in building J. He had been employed at the facility for the past 2 months as the maintenance director. He explained the Air Conditioning (AC) was functioning properly in the residents' rooms, which were all served with central air. However, the common area was not being adequately cooled. He explained building J operates with 3 different AC units: one was replaced about 2 weeks ago (6-ton unit that serves one hallway), the second unit was approximately (that serves the 2nd hallway), and the 3rd one was about (that serves the common area). He explained that approximately 3 weeks ago the facility began obtaining quotes to repair the AC system, and those quotes were in the process of being submitted to corporate for approval. He recalled when he first started 2 months ago, there were no fans in the common areas, and the temperature at that time was cooler. He confirmed that administration was aware. He stated, "I know it is not OK', regarding the closed blinds, fans, and uncomfortable temperature in the common area. He said he did not have any previous knowledge of maintenance record logs or records. On at approximately 11:45 AM, an	A 152		

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A 152	Continued From page 15 interview was conducted with Staff F, homemaker, in building K. She had been employed at the facility for the past 8 years. She serves food to the residents and provides housekeeping. She acknowledged both residents from building K and J were present at that time for lunch. She reported the residents had been coming over for meals for a little bit now without any specific timeframe. On at approximately 12:10 AM, an interview was conducted with Staff H, licensed practical nurse (LPN). She explained that when she works over building J on the weekends, she often brings all 6 residents over to building K, where the environment is more comfortable. She confirmed the AC in the common area of building J had not been working properly for approximately 5 weeks and all 6 residents from building J slept in recliners in the common area of building K last night ( ) and that this was not the first time. In addition to building J, she added buildings C and F are also experiencing issues with non-functional AC. On at approximately 12:50 PM, an interview was conducted with the director of nursing (DON) who questioned why all 6 residents from building J were brought over to building K by Staff B last night, adding that nobody told Staff B to do so. She said the facility had been recording temperatures in building J and explained that fans had been placed in the common area. She said she did not have a log record of the temperatures. She explained that decision making is handled through the executive director (ED) and she is not involved in making any final decisions regarding temperature-related actions.	A 152		

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A 152	Continued From page 16 On at approximately 4:30 PM, a phone interview was conducted with Staff A who explained that on the night of , all 6 residents of building J spent the night sleeping in recliners in the common area of building K because the AC was not working. On , at approximately 1:50PM, an interview was conducted with Resident #7's spouse, a resident in building K. He recalled the AC being nonfunctional in building J for about 6 weeks, and understood that as the reason why the residents were brought over from building J to building K. Record reviews for the six residents of building J included documentation that each resident had a diagnosis which included and notation that each resident had been reassigned to a room in building K on either or . There were no record entries for these residents indicating they were moved to building J, but all staff interviews on , including with the executive director, confirmed the residents were moved to building J at some time prior to the night of . Record review for Resident #11: resides in Cottage (building) J (Memory Care), diagnoses included . The progress note dated documented " Called family to notify of room change for the time being to K15, no concerns at this time. Vitas hospice notify of change". Record review for Resident #2: resides in Cottage J (Memory Care), diagnoses included , identified as an elopement risk on the 1823 Assessment. The progress note dated documented:" Family present spoke with nurse and DON explained AC issue in building J, explained new room in K for temp	A 152		

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A 152	Continued From page 17 move. Family understands. Will update when patient moves ." Record review for Resident #1: resides in Cottage J (Memory Care), diagnoses included with sundowning, at risk for elopement, ambulatory. The progress note dated documented:" resident temporarily moved to building K6 until AC unit is replaced. Family and Hospice notified". Record review for Resident #9: resides in Cottage J (Memory Care), diagnoses included , severe , at risk for elopement, independent with ambulation. The last progress notes on file dated documented:" Family notified of room change, no concerns, explained will move to J once cleared." Record review for Resident #8: resides in Cottage J (Memory Care), diagnoses included , advanced , at risk for elopement. The progress note dated documented:" Talked to wife, patient moved to K, no concerns from family. Vitas Hospice notified" Record review for Resident #10: resides in Cottage J (Memory Care), diagnoses included with Behavioral Disturbances, , cognition, and independent with ADL's. The last progress notes on file dated documented:" 25 Called family of room change, no concerns, Hospice notified, will update when patient moves to J cottage". During an interview on at 3:36pm, the executive director provided a mitigation plan for spot coolers and industrial fans for the affected areas and said she just purchased these and the maintenance director was in the process of picking them up and would immediately install them. She said that the residents from building J had been moved into building K but then they	A 152		

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A 152	Continued From page 18 moved them (to building J) when the AC in the rooms was repaired. When asked why they didn't move residents to building K when these issues in the common area started, she explained that the resident rooms were cooled to a comfortable temperature and they were taken to building K during the day when temperatures were uncomfortable, but did not address the residents' need to socialize or have use of the common areas. According to the Weather Underground website at www.wunderground.com/history/daily/us/fl/pensacola/KFLPENSA29/date/2025- , the high temperature in Pensacola on was 92 degrees Fahrenheit and the low was 80 degrees Fahrenheit at midnight on . On at approximately 3:30 PM, the Executive Director provided Order #WG95356189 for immediate action. The receipt for purchase was reviewed as follows: Lasko Cyclone 18 inches 3 speed Oscillating Pedestal fan X1 Commercial Electric 20 inches 3 speed High Velocity Floor Fan X2 LG 6,000 BTU 115-Volt Portable AC with dehumidifier X5 Portable AC Units for Cottage E/F dining room X2 Portable AC Units for Cottage C dining room Portable AC Units for Cottage J common area X2 An Air conditioning repair company was hired by the facility to work on the units and scheduled to be on site at 4:30 PM to assess the AC units for replacement. They began work on Sunday and all AC compressors/Units were to be replaced and work completed by .	A 152		

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A 152	Continued From page 19 On , the facility provided evidence that repairs were made to the air conditioning (AC) units after the start of the survey and temperature observation was recorded in Memory Care Building J at 12:06 PM, Location: Building J, Common Area, Temp: 73 Fahrenheit (Photographic evidence obtained). Additionally, it was noted that all blinds were closed. There were no fans in the common area. One resident was sleeping on a sofa; 2 other residents were sitting at the table. On , temperature observation was recorded in Assisted Living Building F at 12:01 PM, Location: Building F, Common Area, Temp: 70 Fahrenheit (Photographic evidence obtained). On , temperature observation was recorded in Assisted Living Building C at 12:15 PM, Location: Building C, Common Area, Temp: 77 Fahrenheit (Photographic evidence obtained). The Comprehensive Emergency Management Plan was reviewed and did not include interventions/plan for AC non-functioning. The Maintenance Director job description was reviewed and described job tasks which included "daily walkthrough and duties include cottage/ground walkthrough, reviewing work orders, checking in with staff/team for any concerns/needs, assessing cottages for any temperature/HVAC concerns". The "Maintenance Director Job Description/Onboarding" was reviewed and included the following expectations: "2-Executive Director & Maintenance Director should walk the campus weekly. Items to be	A 152		

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A 152	Continued From page 20 addressed should be recorded and added to the priority list. :30am Morning standups- Maintenance Director, Marketing, Executive Director. -Maintenance Director should bring current log to stand up daily to discuss prioritization. 5- Text to include Maintenance, Executive & Marketing Directors to be used to communicate unexpected urgent items throughout the day 6- Maintenance Log- As requests are reported, they should be logged in the Maintenance receipts book. copy is available for the Maintenance Director // copy to be kept for record 9- Maintenance Director should communicate large facility needs to Executive Director with 3 quotes if possible. -Once approved by Executive Director, Maintenance Director should send an email with a clear summary of the issue, the timeline, quotes, and Maintenance Director's recommendation." The Personal Care Assistant ( ), job description was reviewed and described duties as "Supervise and monitor patients in regard to patient safety ...", "Fully understand all aspects of residents' rights; maintain the comfort, privacy and dignity of each resident in the delivery of services to them". Class II	A 152		