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
	AL11968398	A. BUILDING: _____ B. WING _____	12/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANTA LUCIA ALF, INC	2706 WESTHIGH AVE TAMPA, FL 33614

(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
ZZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the , , are enrolled in the national retained print notification program at the Federal Bureau of Investigation: 1. A person with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. 2. Effective , , , or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity. (c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse. 1. Before , , , initial status and any changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person ' s status has been made. 2. Effective , , , initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person ' s status has been made.	ZZ814		

AHCA Form 3020-0001

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

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ZZ814	Continued From page 1 (d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic , submission to the Department of Law Enforcement. The registration must include the person ' s full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure all staff were registered on the facility's background screening clearinghouse roster for two (Up Administrator and Staff A) of two files sampled. Findings included: An observation on at 11:20 a.m. showed the Up Administrator (BUA) and Staff A interacting with residents. A record review of the BUA and Staff A files, conducted on , revealed the BUA and Staff A were not listed as employees on the facility's background screening roster. During an interview on at 1:15 p.m. the BUA agreed Staff A and the BUA and were not included on the facility's background screening roster. .	ZZ814		

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ZZ814	Continued From page 2 Unclassified	ZZ814		

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A 000	Initial Comments A complaint investigation (complaint number 202501893) was conducted at Santa Lucia ALF on . Deficiencies were identified at the time of survey. A Class I deficiency was found at tag A0030 and A0033. A Class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, , , or to a resident receiving care in a facility A resident was found physically restrained to a wheelchair with a gait belt, preventing the resident from standing or transferring independently, and remained restrained for over seven hours, constituting by inappropriate use of a physical . Additionally, the facility implemented unauthorized visitation restrictions by limiting visitation hours resulting in residents being denied access to visitors of their choice, violating resident rights. The Class I noncompliance began on . The facility's Administrator was notified of the Class I noncompliance on at 4:32p.m. The census at the start of the survey was 5. The following is a description of the deficiencies found at the time of the visit.	A 000		
A 010 SS=D	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency	A 010		

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A 010	Continued From page 1 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care.	A 010		

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A 010	Continued From page 2 (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006	A 010		

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A 010	Continued From page 3 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met:	A 010		

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A 010	Continued From page 4 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure each resident receiving hospice services had an interdisciplinary care form that described the services being provided by hospice and those being provided by the facility for one (Resident #1) of one resident sampled.	A 010		

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A 010	Continued From page 5 Findings included: A record review of resident #1's chart, conducted on , revealed no interdisciplinary care form was available for review. During an interview on at 10:41a.m. the Up Administrator (BUA) stated Resident #1 was admitted to the facility on with hospice services. The BUA advised the facility was unable to produce any documents related to an interdisciplinary care plan or any other agreements the facility had with the hospice agency. Class III	A 010		
A 030 SS=L	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.	A 030		

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A 030	Continued From page 6 (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and , ; 6. Administrative and housekeeping schedules 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	A 030		

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A 030	Continued From page 7 facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (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	A 030		

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A 030	Continued From page 8 make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this 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	A 030		

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A 030	Continued From page 9 facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and 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	A 030		

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A 030	Continued From page 10 Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, 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.	A 030		

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(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 030	Continued From page 11 This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that every resident had the right to live in a safe and decent environment free from and neglect by not restricting mobility within the facility for one of five sampled residents (Resident #1). Additionally, the facility failed to ensure residents were free from interference in exercising their right to receive visitors of their choosing for five of five sampled residents, (Resident #1, Resident #2, Resident #3, Resident #4, and Resident #5). Findings included: An observation on at 9:35 a.m. revealed Resident #1 was seated in a wheelchair in the living room with a gait belt secured across Resident #1's waist with a brace on her right . The gait belt was buckled in the rear of the wheelchair, behind Resident #1, preventing the resident from removing it independently (photographic evidence obtained). Resident #1 was observed attempting to stand but was unable to fully stand due to the gait belt restricting mobility. Additional observations on between 9:35 a.m. and 4:45 p.m. revealed Resident #1 remained restrained in the wheelchair with the gait belt in place, during the duration of the survey. During an interview on at 9:45 a.m., Resident #1, stated she was not restrained and tugged at the gait belt but was unable to remove it. The resident was observed attempting to stand but was unable to get out of the wheelchair independently due to the gait belt restricting mobility.	A 030		

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	AL11968398	A. BUILDING: _____ B. WING _____	12/29/2025

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A 030	Continued From page 12 An observation on at 11:10 a.m. revealed Staff A transported Resident #1 in the wheelchair, while still restrained with the gait belt secured around Resident #1's waist and wheelchair to the restroom. Resident #1 was returned a short time later in the wheelchair with the gait belt still in place, restrained to her wheelchair. An interview conducted on at 12:35 p.m. revealed the -Up Administrator (BUA) stated that Resident #1 remained in the wheelchair with the gait belt applied during daytime hours, unless Resident #1 went to bed. An interview on at 1:06 p.m. Staff B stated the gait belt was placed around Resident #1's waist to prevent Resident #1 from falling from the wheelchair when picking up a toy doll should the doll drop from Resident #1's , . An interview on at 2:15 p.m. the BUA stated the type of belt used on Resident #1 was a gait belt that was usually used for , , , , . The BUA stated the gait belt could not be used as a wheelchair seat belt. A record review of a signed letter dated , on facility letterhead, was in Resident #1 file. The letter noted, "I [health care surrogate] give consent to have a seat belt used, as needed to prevent my father/mother [Resident #1] from falling while seated. I understand that there is a doctor's order, and that the doctor considers it necessary to avoid any ." (photographic evidence obtained). A record review was conducted on of the facility's undated physical policy noted "It is the policy of Santa Lucia ALF that	A 030		

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A 030	Continued From page 13 physical will not be used on the residents". A record review for Resident #1 conducted on revealed no physician's order for the use of a physical from either the primary physician or the hospice physician. The record also lacked a care plan use, a defined time frame for application, documentation specifying the type of permitted, and staff monitoring or observations following application of the . Resident #1 was receiving hospice services for of the and assistance with activities of daily living (ADLs). The resident was admitted to hospice on at home and was admitted to the facility on . A record review of the Owner, Staff B, Staff C, and the -Up Administrator (BUA) employee records, conducted on , revealed that none of the employees had documentation of training on physical devices or any training related to the safe application of . The BUA employee file was not available at the facility for review. During observations on from 9:30 a.m. to 4:45 p.m., no nap or bed rest was observed, and Resident #1 remained restrained in the wheelchair for the entire period. An observation on at 9:30 a.m., revealed the facility's visitation policy was posted on the front door (photographic evidence obtained). The posted sign showed visitation hours were 9:00 a.m. to 11:00 a.m., 1:00 p.m. to 5:00 p.m., and 6:00 p.m. to 7:00 p.m. if necessary.	A 030		

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A 030	Continued From page 14 A record review of the facility's undated visitation policy, noted that residents could receive visits from family and friends daily between 9:00 a.m. and 9:00 p.m. During an interview on at 10:43 a.m. Staff A. revealed that residents were not allowed to have visitors after 5:00 p.m. unless necessary. During an interview on at 2:22 p.m. with Resident #1's family member, the family member stated Resident #1's spouse was denied access to visit when the spouse arrived at the facility at approximately 5:20 p.m., as it was after 5:00 p.m. Class I	A 030		
A 033 SS=J	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	A 033		

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A 033	Continued From page 15 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 ensure residents were free from improper use for one of one resident observed (Resident #1). Resident #1 was observed restrained to a wheelchair for over seven hours with a gait belt secured behind Resident #1's wheelchair, preventing its removal by the resident and restricting the resident's mobility. Findings included: An observation on at 9:35 a.m. revealed Resident #1 was seated in a wheelchair in the living room with a gait belt across Resident #1's waist. The gait belt was buckled in the rear of the wheelchair behind Resident # 1, not allowing the gait belt to be removed by Resident #1 (photographic evidence obtained). Resident #1 was observed trying to stand and was unable to completely stand due to the gait belt across Resident #1's waist restricting mobility to get up. An observation was made on at 9:45a.m. of Resident #1 seated in a wheelchair. Resident #1 attempted to stand but was unable to, due to a gait belt around her waist which was buckled behind the wheelchair. An observation on at 11:10 a.m. revealed Staff A took Resident #1 to the restroom	A 033		

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A 033	Continued From page 16 as Resident #1 was still restrained to the wheelchair. Resident #1 returned a short time later, still restrained to the wheelchair. During an interview on at 9:45 a.m. Resident #1 stated she was not being restrained and tugged at the gait belt around her waist but was unable to remove the gait belt due to it being buckled behind her. When asked if she could remove the gait belt, Resident #1 again tugged at the gait belt but was unable to remove the belt. A record review of Resident #1's file revealed there was no physician order for a physical from either the primary physician or the hospice physician. There was no care plan for use. A review of Resident #1 Health Assessment (AHCA Form 1823) dated revealed Resident #1 was diagnosed with of the ...and walker use listed as a physical limitation. The Health Assessment noted Resident #1 was alert and oriented to self only, required Hospice Services, required precautions with assistance and supervision of activities of daily living (ADLs). During an interview on at 11:15 a.m. with Resident#1's Hospice provider, the Hospice provider stated the resident was admitted to Hospice services on and received nursing and aide services twice a week. Stated Hospice did not order for Resident#1 and that Resident #1 needed assistance walking and did not require the use of a wheelchair or . Resident #1 was admitted to Hospice due to her diagnoses of of the . During an interview on at 12:35 p.m.	A 033		

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A 033	Continued From page 17 the Up Administrator (BUA) stated Resident #1 stayed in the wheelchair with the gait belt during the daytime hours unless Resident #1 went and took a nap. The BUA said when Resident #1 was in bed at night there was no used. During an interview on at 12:58 p.m. the BUA agreed there was no physician order for a physical to be used on Resident #1. During an interview on at 1:06 p.m. Staff B stated the gait belt was placed around Resident #1's waist to prevent Resident #1 from falling from the wheelchair when picking up a toy doll should the doll drop from Resident #1's . During an interview on at 2:15 p.m. the BUA stated the gait belt used on Resident #1 was a gait belt that was used for , and could not be used as a seat belt. A record review of a signed letter dated , on facility letterhead, was in Resident #1 file. The letter noted, "I [health care surrogate] give consent to have a seat belt used, as needed to prevent my father/mother [Resident #1] from falling while seated. I understand that there is a doctor's order, and that the doctor considers it necessary to avoid any ." (photographic evidence obtained). During an interview with the Owner on at 2:05 p.m., the Owner confirmed that she did not have a doctor's order for a for Resident #1. A record review was conducted on of the facility's undated physical policy noted "It is the policy of Santa Lucia ALF that	A 033		

Agency for Health Care Administration

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A 033	Continued From page 18 physical will not be used on the residents". A record review for the Owner, Staff B, Staff C's and BUA employee records, conducted on , revealed the employees did not have any documentation of training on physical devices or any training related to safely applying . An observation on at 4:45 p.m., revealed Resident #1 was restrained in the wheelchair with a gait belt around Resident #1's waist from 9:30a.m. until 4:45p.m. Class I	A 033		