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
	AL11968060	A. BUILDING: _____ B. WING _____	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTSIDE ACTIVE LIVING	1600 TAFT STREET HOLLYWOOD, FL 33020

(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 unannounced Relicensure with Limited Mental Health (LMH) and Generator Monitoring survey was conducted at Eastside Active Living on . Deficiencies were identified related to the LMH and Relicensure. Note: LMH Census: 55	A 000		
A 030	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	A 030		

AHCA Form 3020-0001

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

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A 030	Continued From page 1	A 030		

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 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

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A 030	Continued From page 2 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 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	A 030		

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A 030	Continued From page 3	A 030		

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 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

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A 030	Continued From page 4 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 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	A 030		

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A 030	Continued From page 5 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. This Statute or Rule is not met as evidenced by: Based on interview and record review, it was determined, the facility failed to implement and follow an effective grievance procedure that demonstrated a system for receipt and resolution of all grievances of residents and/or their representatives. This was evidenced by the facility's failure to maintain documentation of resolutions to resident grievances.	A 030		

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A 030	Continued From page 6 The findings included: A review of the facility's grievance policy and procedure revealed the following information: Form Titled: "Client Concern" [no effective date] If you have any concern and/or grievance please complete this form and give to staff. This form will be presented to Administrator or designee in a timely manner Resolution of the matter will be discussed with you by the director or designee. If you have any question above completing this form or need assistance to complete the form please ask staff for assistance. During an interview conducted on at 2:55 PM with the Administrator, he stated he was not responsible for the intake or resolution of grievances. He further stated the Assistant Administrator (Staff G) handled all grievances. At this time, the facility's documentation for the receipt and resolution of grievances was requested. A review of the facility's grievance intake binder containing resident grievances and resident council meeting notes revealed the following information: a) The grievance intake binder contained 14 grievances ranging from 2023 to 2025 and resident council meetings from 2024 to 2025. b) There was no documentation of a resolution being provided for any of the grievances documented in the binder. c) There was no documentation of the resident	A 030		

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A 030	Continued From page 7 council meeting , most of the resident's concerns outside of dietary complaints. d) There were repeat complaints regarding staffing, supervision, and dietary menu items that went unaddressed. During an interview conducted with the Administrator on at 4:43 PM, he stated he was not aware of any residents voicing concerns with staffing, meals or supervision,. He further stated that the Assistant Administrator would know best because she handles the grievances. At this time, he was informed that he was noncompliant with the facility's grievance protocol and this in turn was affecting the residents' environments. Additionally, he was informed that the grievance protocol must address the receipt and resolution of all grievances to ensure the resident's rights are beign honored. The Administrator acknowledged the findings. Class III	A 030		
A 032	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)	A 032		

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A 032	Continued From page 8 (a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family,	A 032		

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A 032	Continued From page 9 guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on interview and record review, it was determined that, the facility failed to provide documentation of staff participation in Elopement Drills conducted twice a year for the year of 2024 for 2 out of 3 sample staff (Staff C and D). The findings included: During an interview on at approximately 11:38 PM with the Administrator, he was informed to provide documentation for the facility's Elopement Drills conducted twice a year for the prior two years. Review of this documentation and sampled personnel files revealed the following. 1) Review of the facility's personnel file for Staff C (Caregiver) with a hire date of revealed Staff C had no documentation of participating in Elopement Drills twice a year. 2) Review of the facility's personnel file for Staff D (Caregiver) with a hire date of revealed Staff D had no documentation of participating in Elopement Drills twice a year. During an interview on at 1:45 PM with the Administrator acknowledged the findings. No additional documentation was provided during	A 032		

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A 032	Continued From page 10 the survey. Class III	A 032		
A 079	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents — Staff Hours/Week 0-5 — 168 212 16-25 — 253 26-35 — 294 36-45 — 335 46-55 — 375 56-65 — 416 66-75 — 457 76-85 — 498 86-95 — 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left	A 079		

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A 079	Continued From page 11 solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and , , ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least , , must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making	A 079		

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A 079	Continued From page 12 decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter	A 079		

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A 079	Continued From page 13 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 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 provide adequate staffing to meet the care needs of the current resident census (81 of 81 residents). This was evidenced by the facility's failure ensure they had sufficient staff to provide supervision and care for the residents receiving services under the facility's Limited Mental Health (LMH) license.	A 079		

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A 079	Continued From page 14 This directly threatens the physical, emotional health, and safety of all residents (census of 81) . The findings included: A review of the facility's supervision policy provided by the Administrator revealed the following information: Resident Care and Supervision Policies and Procedures A) It is the policy of Eastside Active Living to provide care and services appropriate to the needs of the residents accepted for admission to the facility. (1) Supervision. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) 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. (b) Maintaining a general awareness of the resident's whereabouts. (c) Maintaining a written recordm updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in method of medication administration, or other changes that resulted in the provision of additional services. (2) Activities of Daily Living. Facilities must offer supervision of or assistance with activities of daily living as needed by each resident.	A 079		

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A 079	Continued From page 15 (3) Elopement Standards. (a) All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. Below are the following observations, interviews, and record reviews completed on that demonstrate noncompliance due to a lack of supervision, documentation, and provision of care and services: 1) During a confidential interview with a representative of a resident, it was revealed that Resident#15 had eloped two times from the facility's secure care unit twice within the last two months. Subsequently, a request was made for Resident #15's file. A record review of Resident#15's file revealed an incident report titled "ALF Incident Report", signed by Staff E(caregiver) on . The document revelaed the following: On at 4:30 PM Resident #15 was not found in his room (special care unit) all caregivers (did not document how many staff members were looking for the resident) were checking every room Patio and parking lot. After 10 minutes a resident that resides in the non-secure care unit informed staff that Resident#15 was in the parking lot near Taft Street that runs east and west (approximate distance from secure care unit to Taft Street is approximately 350). Further review of the Resident#15's file review revealed an untitled form that stated the following: a) Date: b) Resident#15 complete name	A 079		

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A 079	Continued From page 16 c) Time of the incident and notes: 911 was called for resident as missing person. There was no documentation of the previously mentioned second elopement in the resident's file. An additional record review of Resident#15's file revealed he was admitted to the facility on as a Limited Mental Health (LMH) resident. Further review revealed a Health Assessment (1823 AHCA Form) dated , that documented medical and history diagnoses as ( ), ; Physical and sensory limitations as needs assistance with medication; status as . An indication of Elopement Risk was not documented (left blank on the form). The Activities of Daily Living (ADLs) were documented as needed assistance with ambulation, bathing, , eating, self-care, toileting and transferring (staff provides assistance with the resident's participation). During an interview conducted with the Administrator on at 11:15 AM, he stated the Secure Care unit was a small unit and he was unable to confirm census at the time of elopement (roughly 80). Additionally, the Administrator stated the facility was not locked down facility and there were no secured units. At this time, he was asked to provide a copy of the staffing schedule for the month of (incident date). A review of the staffing schedule for revealed staff members were assigned three shifts for the Assisted Living (AL) and Secure Care Unit:	A 079		

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A 079	Continued From page 17 7:00 AM - 3:00 PM 3:00 PM - 11:00 PM 11:00 PM - 7:00 AM Further review of the staffing schedule for revealed that on , 4 staff members were assigned to work in the facility to provide care and services and supervision to roughly 80 residents. However, staffing schedule did not detail which staff member(s) are assigned to cover the Secure Care Unit. During an interview conducted with Staff E (Caregiver) on at 3:35 PM, she confirmed she was the staff on duty on the day of the incident on . Staff E confirmed the Secure Care Unit is a small area and only one employee is always assigned to that unit. Staff E stated there was no other staff to relieve her during shift and she was responsible for all of the residents in the Secure Care Unit. Staff E further stated when the elopment occurred, she completed the search for resident on her own because the other staff were unavailable. During an interview conducted with Staff H on at 4:03 PM, she stated that resident have eloped from the facility within this past year. Additionally, she stated that the residents are up all night during her shift (11:00 PM-7:00 AM) and exhibit exit seeking behavior around 2:00 AM due to them wanting to go outside and smoke. She further stated there is no security at the facility and on multiple occasions she was the only staff on shift when staff called out. Staff H then stated she did not think it was safe for any staff to be working alone with 81 residents. During an interview conducted with the Administrator on at 4:15 PM, he	A 079		

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A 079	Continued From page 18 confirmed Resident #15 had eloped from the facility on . He stated he received a call (unknown time) from Staff G (Assistant Administrator) , that the police had found resident (unknown location and time) and took him a local hospital where he was admitted for two days. When asked to provide documentation from the police and hospital, he stated he did not have any. At this time, the Administrator was asked to provide a list of residents that were identfied as an elopement risk. He stated the facility did not admit residents that were an elopement risk. When asked what the facility had to to prevent another elopement, the Administrator stated they increased the supervision by telling the staff to pay more attention to the residents. 2) On at 8:35 AM, a medication pass was observed being conducted by only one Medication Technician(Staff B) while there were 12 residents lined up in the hallway in front of the Assistant Administrator's office. Further observation revealed many of the residents used wheelchairs and rolling walkers as assistive devices while waiting in line to be assisted with self-administration of medications. During an interview conducted with Staff B (Medication Technician) on at 8:40 AM she stated she was the only medication technician on this shift (7:00 AM-3:00 PM) and there were two other care staff present. Staff B further stated the current census was approximately 75 residents. At this time, AHCA intervened and requested Staff B find another staff to assist with the medication pass. At 8:50AM Staff B stated she called the Administrator and he stated that Staff C (Caregiver/Medication Technician) could assist with medication pass.	A 079		

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A 079	Continued From page 19 On at 9:00 AM Staff C was observed telling the residents in line to wait while she assisted Resident #11. Staff C then pushed Resident #11 in her wheelchair into the hallway near her room while the other dozen residents waited for their medications. During an interview conducted with Resident #11 on at 9:10 AM, she stated she required assistance with her ADLs because she was visually . . When asked if the staff reguarly assisted the resident with finding her room, Resident #11 stated the staff was too busy, so she had learned to find her way around the building. On at 9:35 AM, it was observed that the medication pass was still ongoing despite Staff B and Staff C both completing the task. Additionally, there was only one available care partner (assigned to the secure care unit) on site to supervise the residents and provide care and services. During an interview conducted with Staff C (Caregiver) on at 12:15 PM, she stated the facility needed more staff. She further stated her job dutites required her to assist with breakfast and lunch meals, set up tables and cutlery, and throw away garbage. Additionally, she stated in between those tasks, she does medication pass and care and services. Staff C stated the ratio was approximately 60 residents to 1 care staff (CNA). Staff C further stated the morning shift (7 am- 3 pm) was extremely overwhelming and busy due breakfast, medication pass, and third party visits (, , Hospice) all occuring at once. Lastly, Staff C stated there was orignally 3 medication techicians	A 079		

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A 079	Continued From page 20 in addition to the care partners on the 7:00 AM-3:00 PM shift; now there was only 1 medication technician to support the 2 care staff. 3) A review of the facility's grievance policy and procedure revealed the following information: Form Titled: "Client Concern" [no effective date] If you have any concern and/or grievance please complete this form and give to staff. This form will be presented to Administrator or designee in a timely manner Resolution of the matter will be discussed with you by the director or designee. If you have any question above completing this form or need assistance to complete the form please ask staff for assistance. During an interview conducted with the Administrator on at 2:55 PM, he stated he was not responsible for the intake or resolution of grievances. He further stated the Assistant Administrator (Staff G) handled all grievances. At this time, the facility's documentation for the receipt and resolution of grievances was requested. A review of the facility's grievance intake binder containing resident grievances and resident council meeting notes revealed the following concerns from 2024-2025: a) Grievances: I) A handwritten letter dated written by an unidentified resident regarding Resident #9 stated the following: On around 7:40 AM Resident #9 had called the resident to inform her that she in	A 079		

Agency for Health Care Administration

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A 079	Continued From page 21 room and could not get up. The unidentified resident then entered her manual wheelchair and began rushing to Resident #9 's room. As the unidentified resident passed the nursing station, she saw Staff C (CNA Lead, Medication Technician) passing medications to residents. The resident then informed Staff C that Resident #9 and needed help. Staff C did not respond to the unidentified resident and continued med pass. The resident asked Staff C several times to assist before Staff C finally responded, "Go and look for a CNA". The resident then stated she left the nursing station and attempted to open Resident #9's door to assist her by herself. The door was locked and the resident stated she had to get assistance from housekeeping and it was housekeeping and 2 other care staff that assisted Resident #9 off the floor into the wheelchair. The resident stated Staff C's behavior was rude and uncalled for. II) A document titled, "Suggestions" dated with resident signatures (identified by the Administrator) stated the following regarding an unidentified resident's : "There have been situation when a resident has or need help. The resident could be having a , or even from a . There's no way to call anybody, you're completely alone. A resident has been in his room for about three of four days without anybod noticing that he's in his room, the only person that noticed was a housekeeper. Nobody comes to ask him if he needs anything or if he is ok. There's no way to get a hold of anyone beacuse there's nothing. There should be something fot residents to have so they can be able to communicate with CNA's if there are in any danger. Also, there should be mandatory check for residents during the day and	A 079		

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A 079	Continued From page 22 night times." III) An email letter dated at 4:45pm sent by an unidentified resident to the Assistant Administrator stated the following: "There are three shifts here on Eastside, 7AM to 3PM -3PM-11PM and 11PM to 7AM. Of the three shifts, 3 to 11 it's the not so good one. They spend their shift doing absolutely nothing. They hide and talk in the phone, watch TV, some go to their care and spend around an hour sometimes 2 hours an in the meantime residents need help. " b) Resident Council Meetings: I) Resident Council Meeting Notes dated (18 residents present) revealed the following information: Minutes of the Resident Council Meeting The meeting covered the following topics: 1. Greetings/ introductions/ annoucements 2. Safety, housekeeping, laundry 3. Food & Dining . Laundry 5. Don't keep calling 911 for everything 6. Activity Dpt. 7. Q & A Nursing Residents : We are still having a hard time finding staff at night. Staff : I will talk to the Assistant Administrator about that. Please try to follow the rules.	A 079		

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A 079	Continued From page 23 Resident Council Meeting Notes dated (21 residents present) revealed the following information: Minutes for the Resident Council Meeting Resident #16: stated that she wants to live in an environment where she feels safe. She stated that there are people going around knocking on doors late at night. The was no response that addressed this concern documented in the council notes. During an interview conducted with the Administrator on at 4:43 PM, he stated he was not aware of any residents voicing concerns with staffing or supervision. He further stated that the Assistant Administrator would know best because she handles the grievances. Class III	A 079		
A 080	429.52( ) FS; 59A-36.011(1) FAC Training - Core & Competency Test 429.52 (2) Administrators and other assisted living facility staff must meet minimum training and education requirements established by the agency by rule. This training and education is intended to assist facilities to appropriately respond to the needs of residents, to maintain resident care and facility standards, and to meet licensure requirements. (3) The agency, in conjunction with providers, shall develop core training requirements for	A 080		

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A 080	Continued From page 24 administrators consisting of core training learning objectives, a competency test, and a minimum required score to indicate successful passage of the core competency test. The required core competency test must cover at least the following topics: (a) State law and rules relating to assisted living facilities. (b) Resident rights and identifying and reporting , neglect, and , . (c) Special needs of elderly persons, persons with mental illness, and persons with , and how to meet those needs. (d) Nutrition and food service, including acceptable sanitation practices for preparing, storing, and serving food. (e) Medication management, recordkeeping, and proper techniques for assisting residents with self-administered medication. (f) Firesafety requirements, including fire evacuation drill procedures and other emergency procedures. (g) Care of persons with 's and related . 59A-36.011 (1) ASSISTED LIVING FACILITY CORE TRAINING REQUIREMENTS AND COMPETENCY TEST. (a) The assisted living facility core training requirements established by the department pursuant to section 429.52, F.S., shall consist of a minimum of 26 hours of training plus a competency test. (b) Administrators and managers must successfully complete the assisted living facility core training requirements within 3 months from the date of becoming a facility administrator or manager. Successful completion of the core	A 080		

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A 080	Continued From page 25 training requirements includes passing the competency test. The minimum passing score for the competency test is 75%. Administrators who have attended core training prior to , , , and managers who attended the core training program prior to , , , shall not be required to take the competency test. Administrators licensed as nursing home administrators in accordance with chapter 468, part II, F.S., are exempt from this requirement. (c) Administrators and managers shall participate in 12 hours of continuing education in topics related to assisted living every 2 years. (d) A newly hired administrator or manager who has successfully completed the assisted living facility core training and continuing education requirements, shall not be required to retake the core training. An administrator or manager who has successfully completed the core training but has not maintained the continuing education requirements will be considered a new administrator or manager for the purposes of the core training requirements and must: 1. Retake the assisted living facility core training; and, 2. Retake and pass the competency test. (e) The fees for the competency test shall not exceed $200.00. The payment for the competency test fee shall be remitted to the entity administering the test. A new fee is due each time the test is taken. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that an appointed Assistant Administrator had completed the Core Training and Competency Requirements.	A 080		

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A 080	Continued From page 26 The findings included: During an interview conducted with the Administrator on at 10:30 AM, he stated that he was the Administrator currently and he had an Assistant Administrator (Staff G). When asked who was responsible for the daily operation of the facility, he stated Staff G was his designee. When asked if Staff G was present in the facility, he stated that she was currently on vacation, but she was usually at the facility everyday. At this time, a request was made for the Administrator and Staff G's file. A review of the facility's organizational chart identified Staff G at the top of the staffing hierarchy under the Assistant Administrator role. A review of Staff G (Assistant Administrator) 's file revealed a hire date of . Further review revealed Staff G did not pass the CORE exam and had not retained a CORE license at the time of survey. Additionally, Staff G's file contained a staffing schedule that had staffing hours for the Administrator, Staff G, Staff B-H, F (Care Partners and MedTechs). During an interview conducted with the Administrator on at 2:34 PM when asked about Staff G's CORE License, he stated that Staff G did not pass the CORE licensure exam on her first attempt. At this time, the Administrator was informed that Staff G could not perform administrative duties without a CORE License. The Administrator acknowledged the findings. Class III	A 080		

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AL241	Continued From page 27	AL241		
AL241	429.075( ); 59A-36.020(2) FAC LMH - Records 429.075 (3) A facility that has a limited mental health license must: (a) Have a copy of each mental health resident's community living support plan and the , agreement with the mental health care services provider or provide written evidence that a request for the community living support plan and the , agreement was sent to the Medicaid managed care plan or managing entity under contract with the Department of Children and Families within 72 hours after admission. The support plan and the agreement may be combined. (b) Have documentation provided by the department that each mental health resident has been assessed and determined to be able to live in the community in an assisted living facility that has a limited mental health license or provide written evidence that a request for documentation was sent to the department within 72 hours after admission. (c) Make the community living support plan available for inspection by the resident, the resident's legal guardian or health care surrogate, and other individuals who have a lawful basis for reviewing this document. (d) Assist the mental health resident in carrying out the activities identified in the resident's community living support plan. (4) A facility that has a limited mental health license may enter into a . agreement with a private mental health provider. For purposes of the limited mental health license, the private mental health provider may act as the case manager.	AL241		

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	AL11968060	A. BUILDING: _____ B. WING _____	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTSIDE ACTIVE LIVING	1600 TAFT STREET HOLLYWOOD, FL 33020

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AL241	Continued From page 28 59A-36.020 (2) RECORDS. (a) A facility with a limited mental health license must maintain an up-to-date admission and discharge log containing the names and dates of admission and discharge for all mental health residents. The admission and discharge log required in rule 59A-36.015, F.A.C., satisfies this condition provided that all mental health residents are clearly identified. (b) Staff records must contain documentation that designated staff have completed limited mental health training as required by rule 59A-36.011, F.A.C. (c) Resident records must include: 1. Documentation, provided by a mental health care provider within 30 days of the resident's admission to the facility, that the resident is a mental health resident as defined in section 394.4574, F.S., and that the resident is receiving social security , or supplemental security income and , as follows: a. An affirmative statement on the Alternate Care Certification for , ( ) form, CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-03988, that the resident is receiving SSI or SSDI due to a mental , b. Written verification provided by the Social Security Administration that the resident is receiving SSI or SSDI for a mental . Such verification may be acquired from the Social Security Administration upon obtaining a release from the resident permitting the Social Security Administration to provide such information, or c. A written statement from the resident's case	AL241		

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AL241	Continued From page 29 manager or other mental health care provider that the resident is an adult with severe and persistent mental . The case manager or other mental health care provider must consider the following minimum criteria in making that determination: (I) The resident is eligible for, is receiving, or has received mental health services within the last 5 years, or (II) The resident has been diagnosed as having a severe or persistent mental . 2. An appropriate placement assessment provided by the resident's mental health care provider within 30 days of admission to the facility that the resident has been assessed and found appropriate for residence in an assisted living facility. Such assessment must be conducted by a psychiatrist, clinical psychologist, clinical social worker, , , nurse, or an individual supervised by one of these professionals. a. Any of the following documentation that contains the name of the resident and the name, signature, date, and license number, if applicable, of the person making the assessment, meets this requirement: (I) Completed Alternate Care Certification for , , ( ) form, , , CF-ES Form 1006, (II) Discharge Statement from a state mental hospital completed no more than 90 days before admission to the assisted living facility provided it contains a statement that the individual is appropriate to live in an assisted living facility, or (III) Other signed statement that the resident has been assessed and found appropriate for residency in an assisted living facility. b. A mental health resident returning to a facility from treatment in a hospital or crisis stabilization unit will not be considered a new admission and	AL241		

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AL241	Continued From page 30 will not require a new assessment. However, a break in a resident's residency that requires the facility to execute a new resident contract or admission agreement will be considered a new admission and the resident's mental health care provider must provide a new assessment. 3. A Community Living Support Plan. Each mental health resident and the resident's mental health case manager must, in consultation with the facility administrator, prepare a plan within 30 days of the resident's admission to the facility or within 30 days after receiving the appropriate placement assessment in paragraph (2)(c), whichever is later, that: a. Includes the specific needs of the resident that must be met in order to enable the resident to live in the assisted living facility and the community, b. Includes the clinical mental health services to be provided by the mental health care provider to help meet the resident's needs, and the frequency and duration of such services, c. Includes any other services and activities to be provided by or arranged for by the mental health care provider or mental health case manager to meet the resident's needs, and the frequency and duration of such services and activities, d. Includes the of the facility to facilitate and assist the resident in attending and arranging transportation to for the services and activities identified in the plan that have been provided or arranged for by the resident's mental health care provider or case manager, e. Includes a description of other services to be provided or arranged by the facility, f. Includes a list of factors pertinent to the care, safety, and welfare of the mental health resident and a description of the signs and symptoms to the resident that indicate the	AL241		

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AL241	Continued From page 31 immediate need for professional mental health services, g. Is in writing and signed by the mental health resident, the resident's mental health case manager, and the assisted living facility administrator or manager and a copy placed in the resident's file. If the resident refuses to sign the plan, the resident's mental health case manager must add a statement that the resident was asked but refused to sign the plan, h. Is updated at least annually or if there is a significant change in the resident's behavioral health, i. , include the , Agreement described in subparagraph (2)(c)4. If included, the mental health care provider must also sign the plan; and, j. Must be available for inspection to those who have legal authority to review the document. 4. , Agreement. The mental health care provider for each mental health resident and the facility administrator or designee must prepare a written statement, within 30 days of the resident's admission to the facility or receipt of the resident's appropriate placement assessment, whichever is later. The statement: a. Provides procedures and directions for accessing emergency and after-hours care for the mental health resident. The provider must furnish the resident and the facility with the provider's 24-hour emergency crisis telephone number; b. Must be signed by the administrator or designee and the mental health care provider, or by a designated representative of a Medicaid prepaid health plan if the resident is on a plan and the plan provides behavioral health services in section 409.912, F.S.; c. , cover all mental health residents of the	AL241		

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AL241	Continued From page 32 facility who are clients of the same provider; and, d. , be included in the Community Living Support Plan described in subparagraph (2)(c)3. 5. Missing documentation 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 appropriate party. A documented request for such missing documentation made by the facility administrator within 72 hours of the resident's admission will be considered a good faith effort. The documented request must include the name, title, and phone number of the person to whom the request was made and must be kept in the resident's file. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain the required records for the provision of the Limited Mental Health (LMH) services license. This was evidenced by the facility's failure to ensure the entire LMH census (55 residents) had completed an assessment by their mental health providers within 30 days of admission to determine their eligibility reside in an assisted living facility. Additionally, the facility's failed ensure the admission and discharge log was updated for all LMH residents. The findings included: During an interview with the Administrator on at 10:35 AM, he stated the facility was licensed to provide Limited Mental Health Services. At this time, the admission discharge log and additionaly LMH documentation were requested. 1) A review of the facility's Limited Mental Health documentation (binder) revealed the following	AL241		

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AL241	Continued From page 33 information: a) The facility had 55 residents that were LMH residents b) All 55 residents had , Agreements and Community Living Support Plans that wee completed on . c) All 55 residents were missing the appropriateness placement assessment from their mental health providers. 2) A review of the facility's admission and discharge log revealed that there were only 21 residents under the LMH licensure that were currently residing in the community. Additionally, 29 out of the 55 residents that were in the facility's LMH documentation were not documented as being under the LMH licensure in this log. During an interview conducted with the Administrator and the Business Office Manager at 1:47 PM, they stated the did not have a census count for the total amount of LMH residents. At this time, AHCA intervened and requested they identify all LMH residents. The Business Office Manager provided a list of 55 residents that were currently under the LMH license. The names matched the documentation that facility provided for the LMH licensure. During an interview conducted with the Administrator at 5:13 PM, he was informed that the 55 residents were all missing their appropriatness assessments and there is no documentation of a determination that they are eligble to live in an assisted living facility. Additionally, he was informed that his admission and discharge log identified less than half of the current LMH census and this noncompliance puts	AL241		

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AL241	Continued From page 34 the LMH residents at risk. The Administrator acknowledged the findings. Class III	AL241		
A 165	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or	A 165		

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A 165	Continued From page 35 its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of	A 165		

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A 165	Continued From page 36 s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on interviews and record review, it was determined that, the facility failed to report an Elopement. The facility failed to submit an Adverse Incident Report within one business day after the occurrence of an adverse incident for Resident #15. The findings included: During confidential interviews on between 9:00 AM and 4:00 PM revealed Resident #15 had eloped from the facility (Special Care Unit) on . During an interview on at approximately 9:45 AM with the Administrator, he was informed to provide the facility's incident reporting documentation and Resident #15's file. During facility record review on , it was	A 165		

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A 165	Continued From page 37 revealed that the facility had documented an incident report for Resident #15, titled, ALF Incident Report signed and dated on . Further review revealed Resident#15 was found by the local police and sent to the local hospital. During an interview on at approximately 12:50 PM, the Administrator confirmed the facility failed to submit an Adverse Incident Report to the Agency for the Healthcare Administration (AHCA) within one business day after the occurrence of an adverse incident. Record review of Resident#15 revealed he was admitted on Limited Mental Health (LMH) resident. Further review revealed a Health Assessment (1823 AHCA Form) dated documented as follows: 1) Medical and history diagnoses as ( ), . 2) Physical and sensory limitations as need assistance with medication. 3) status as . 4) Assistance with Activity of Daily Living (ADLs) was documented as needs assistance for ambulation, bathing, , eating, self-care, toileting and transferring (staff provides assistance with the resident's participation). During an interview on at approximately 4:15 PM team of surveyors met with the Administrator and he acknowledged the findings. Class III	A 165		