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
	AL11970300	A. BUILDING: _____ B. WING _____	12/09/2025

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BELMONT VILLAGE CORAL GABLES	4111 SALZEDO ST CORAL GABLES, FL 33146

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A 031 SS=F	59A-36.007(6) FAC Resident Care - Third Party Services (6) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, , and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the , resident's needs. (c) The administrator or designee must ensure that: 1. Care coordination includes documented communications about the resident's condition and response to treatment or services ordered by the physician which may impact the resident's appropriateness for continued residency in the facility; 2. Communications occur at least once every 30 days and whenever there is a significant change in the resident's condition; and 3. If physician ordered treatments or services	A 031		

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A 031	Continued From page 1 occur less often than once a month, communications must be conducted according to the ordered treatment or service schedule and whenever there is a significant change in the resident's condition. 4. When communication with the third party provider is unsuccessful, at least two attempts at communication on two separate days must be documented. Documentation must include the name of the person from the third party provider with whom contact was attempted, the method of communication, and the date and time of the attempts. This documentation must be included in the resident's record in accordance with the timeframes in subparagraphs 59A-36.007(6)(c)2. and 3. (d) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that residents had the choice to self-select the pharmacy they wanted to use for their prescription services. Findings: Interviewed on at 7:47 AM by the elevator with medication in her , Resident #16 stated her pharmacy was in Boca Raton but the staff told her she must go through the facility's	A 031		

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A 031	Continued From page 2 pharmacy to get her medication. A review of resident records revealed that in the contract section, residents were asked to complete a document "Preferred Pharmacy for Medication management with Belmont Village." A review of the resident contracts revealed that a preferred pharmacy for resident prescriptions and medication was documented. Further review revealed that the contract stated if residents opted to use their own pharmacy, they would be charged an additional fee. Class III	A 031		

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A 000	Initial Comments A complaint investigation (#2025014832, #2025017060, & #2025017213) was conducted on at Belmont Villages Coral Gables. The provider had deficiencies at the time of the survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of	A 025		

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A 025	Continued From page 1 resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to provide adequate supervision and ensure the health, safety and physical and/or mental wellbeing for three out of 15 sampled residents (#1, #2 and #3). Findings included: #1) Observation on at 7:27 am showed Resident # 1 was in bed sleeping with half bed rails on both sides of the bed. A stand assist patient transport was observed by the window.	A 025		

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A 025	Continued From page 2 (photographic evidence obtained) According to Ergonomics Health, "Sit to stand lifts are designed to assist a person in both standing but also in moving short distances." A review of Resident 1's progress notes showed that on resident and was hospitalized and on returned to the facility from rehabilitation. A review of Resident #1's health assessment dated showed that she had diagnosis of hematoma, , . Resident #1 had and precautions and needed assistance with ambulation, bathing, , grooming, toileting, transferring, and was independent with eating. Resident #1 needed assistance with self-administration of medications. A review of Resident #1's hospital discharge on showed that Resident # 1 had an as well as nondisplaced involving the left pubic symphysis, left , and left . Additionally, the emergency physician reviewed a previous computed , , from that showed an acute to subacute in the right hemispheric space. A review of Resident #1's records showed that the facility did not update the health assessment after the on . A review of the Resident #1's contract showed that 'if it is determine that it is necessary to provide you with one -on-one care in order to protect your health and safety or the health or	A 025		

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A 025	Continued From page 3 safety of others, we will provide such care and you will be charges for it in accordance with the fees set forth in Appendix A.' During an interview on at 2:29 pm the Executive Director stated that Resident # 1 had three one-on-one caregivers employed by the facility, and that they only had basic knowledge on how to use stand assist. A review of the policy regarding assistive devices showed that 'each device used should be documented in the resident record; staff should be familiar with how to safely operate to assisted device; the director of resident care will schedule training on the device; staff shall ensure the device is clean and in good repair each time assistance is rendered; staff shall observed the use of the device and report any concerns. #2) During an interview on at 6:28 am Staff D (caretaker) stated that Resident #3 was found in stairwell when she was asked if any residents had eloped. Observation on at 6:28 am showed that Resident # 3 was not in his room and was not in the facility. Resident # 3's room was in the memory care section of the facility. A review of Resident # 3's health assessment dated showed that he had a diagnosis history of and . Resident #3 had precautions and was not a not elopement risk. Resident # 3 needed assistance with ambulation, bathing, toileting, transferring, Resident # 3 needed supervision with and grooming and was	A 025		

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A 025	Continued From page 4 independent with eating. A review of Resident # 3's progress notes showed that there was no notation that he was found in the stairwell. However, the progress notes stated that on the Resident slapped an employee on the , yet there was a mention of no distress or agitation. Further review showed that on Resident # 3 was found on the floor covered in after the system was triggered. The resident was assessed and return to bed. On Resident # 3 t was found again on the floor after the system was triggered and the resident could not say how he the resident was assessed and returned to bed. On Resident #3 yet again and was transported to hospital because of . A review of Resident # 3 hospital discharge dated showed that he was brought to the emergency department via ambulance for generalized and low , . On admission , was noted, however the had resolved without a course . At discharge he was diagnosis with generalized due to polypharmacy his , was discontinued and , , 100 mg was adjusted for bedtime use. A review of Resident #3's records showed that the facility did not document the resident mental health conditions or the incident that the resident was found in the stairwell after going missing. Further review found no documentation of reassessment or interventions after the . Class II	A 025		

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A 030	Continued From page 5	A 030		
A 030 SS=G	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close 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	A 030		

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A 030	Continued From page 6 facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible 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	A 030		

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A 030	Continued From page 7 of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the 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	A 030		

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A 030	Continued From page 8 prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care 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.	A 030		

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A 030	Continued From page 9 (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for 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.	A 030		

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A 030	Continued From page 10 429.27 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 observation, record review and interview, the facility failed to ensure three (1, #2, #15) out of 15 sampled residents live in a safe and decent living environment, free from and neglect. The facility failed to ensure Resident #1 was provided adequate and appropriate health care, and an evaluation for a higher level of care due to multiple , including a recent resulting in hematoma and a , . The facility failed to provide care for Resident #2 who was found in his wheelchair by his wife a day later wearing the same clothes from the previous day. The facility failed to prevent Resident #2 who needed total care from falling after he was asked by Staff Q (Personal Assistant Laison) to stand to provide a bath	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	A 030		

resulting in . The facility failed to provide Resident #2 with a 45-day discharge notice of relocation or termination of residency from the facility unless, for medical reasons, the resident was certified by a physician to require an emergency relocation to a facility providing a more skilled level of care. The facility failed to have a readily accessible telephone on each floor of each building where residents reside. The facility failed to allow Resident #15 to install a camera in his room for additional security.

Findings:

1)

A review of Resident #1's records only found progress notes from the month of , , through showed no arrangements were made with her primary care physician about leading up to her on .

A review of Resident #1's hospital record dated showed: "Patient had an unwitnessed found by daughter on the floor. Patient denies knowledge of falling and complained of left , , . Immediately upon arrival to the emergency room via fire rescue, we examined the patient. It was obvious the patient has shortening of the lower extremity external rotation which is consistent with a , . The patient had a moderate-sized hematoma to her left forehead area, so we decided to do a CT of the as well as well as a CT of the , bone extending into the left . Differential diagnosis include, but not limited to: , , , . External notes reviewed: I have looked at the previous visits to the hospital. I see that on , , the patient had a CT

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A 030	Continued From page 12 that showed the patient had acute to subacute in the right hemispheric space." The Cleveland Clinic states that a occurs when the ball of your ( ) pops out of its socket. It is a medical emergency. A is acutely painful and disabling. Immediate care reduces the chance of long-term complications. The Cleveland Clinic states that a is a break in one or more of your bones in your are an uncommon type of that can range from mild to severe. While mild usually don't require surgery, severe have to be fixed with surgery. A review of Resident #1's health assessment dated showed a diagnoses of a Hematoma (SDH), , and ( ). The physical status showed as notes. The status showed alert, calm and . The special precautions showed and . The activities of daily living showed assistance needed with ambulation, bathing, , self-care, toileting, transferring, and independent with eating. The resident needed assistance with self-administration with medications. However, there were no arrangements made for Resident #1 to been by her primary care physician after on and discharge and return to facility on . A review of Resident 1's progress notes showed dated documented: "Resident observed in apartment. Alert, awake and oriented times two with periods of . Resident	A 030		

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A 030	Continued From page 13 flows verbal command and need constant re-orientation. Resident complains of and discomfort. And symptoms. However, there were no arrangements made for Resident #1 to see her primary care physician. Interviewed om at 9:07 AM Staff H Private Personal Assistant Laison (PPAL) stated that she was with Resident #1 now for 12 hours. When asked when Resident #1 her , , Staff H stated that it was about a month ago. Staff H stated, "She inside her apartment. I think it was in the bathroom." Staff H stated that the resident had an original PPAL) from 9:30 AM-2:30 PM and now since after the it was now from 9:00AM to 9:00 PM. Staff H stated, "I am a certified nursing assistant (CNA). She used a steady and a wheelchair. She needed two people to assist her. I think she after 2:30 PM on . " 2) A review of Resident #2's progress notes dated showed while resident was provided a bed bath resident was screaming due to staff changing clothes and wife complained that the resident had , . However, there were no arrangements made to his primary care physician. A review of progress notes dated showed Staff P's (License Practicing Nurse) initials: "Nurse called to unit to evaluate and assist the resident. Upon arriving to the apartment, resident was observed laying supine but comforted with pillows underneath his and , . Resident was lowered to the ground due to having an unsteady gait and balance.	A 030		

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A 030	Continued From page 14 Resident has a on both , but is in stable condition. Wife insisted on further medical attention and voiced she wants her husband seen at the hospital. Emergency medical services was contacted and arrived to the apartment to further assist and transfer the resident to the hospital. Wife accompanied husband/ to the hospital." Interview on at 9:46 AM Staff P stated that she did not find Resident #2 on the floor on in the morning. Staff P stated that she was called to the room. Staff P stated that Resident #2 a lot. Staff P stated, "He one time with me. He a lot because he was too heavy. Staff P stated that Resident #2 about five times. Staff P stated that when he on , Resident #2 hit his against the cabinet. When asked who called her to the room, Staff P stated that it was Staff Q (Personal Assistant Laison) and another employee who no longer worked in the facility. When asked to explain how Resident #2 was left in a wheelchair overnight with the same clothes on from and was found by his wife, Staff P stated, "I am not sure about the wheelchair. I worked from 6:00 AM-3:00 PM. 32 hours weekly. The wife was not pleased with the care." When asked why he was asked to stand to be showered when he was bedridden, Staff P could not explain. Staff P stated that the resident was given baths in his bed. Staff B stated that before he went out to the hospital, it took people to care for him. Staff P stated, "I don't think he was fit for the facility. I know in the memory care they would only staff three people." Staff P stated that they would have to call fire rescue at times to assist them to get off the floor. A review of the facility records found no staff	A 030		

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A 030	Continued From page 15 assignment schedules for the memory care floor on and to determine who were assigned when Resident #2 was found in a wheelchair a day later wearing the same clothing. A review of Resident #2's health assessment dated showed a diagnosis of . The physical status showed non-ambulatory. The status and the nursing requirements were left blank. The special precautions showed precautions. The activities of daily living showed the resident needed total care in ambulation, bathing, , self-grooming, eating, toileting and transferring. The resident needed assistance with self-administration of medications. A review of Resident #2's records found no 45-day discharge notice of relocation or termination of residency from the facility or discharge letter for medical reasons certified by a physician to require an emergency relocation to a facility providing a more skilled level of care. Interviewed on at 10:16 AM when asked about the reason why Resident #2 was not allowed to return to the facility, the Executive Director stated that Resident #2 needed a higher level of care. However, the Executive Director was unable to provide a letter of discharge. Interviewed on at 11:35 AM when asked for the doctor's discharge letter where Resident #2 needed a higher level of care, the Director of Resident Care stated, "I was not here. I don't have a discharge document." A review of the admissions and discharge log showed Resident #2 was discharged on .	A 030		

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A 030	Continued From page 16 3) Interviewed on at Resident #15 stated at 7:53AM Resident #15 stated that no cameras were allowed in the apartment per their policy. Resident #15 stated, "Their lease says no cameras are allowed. They made us sign." A review of the residents' contracts involving cameras in rooms, read that the residents were not allowed to have cameras in their rooms. Interviewed on at 10:16 AM when asked about residents not allowed to have cameras in their rooms, the Executive Director stated that it was as per the [Agency] the residents can't have a camera in their rooms. When the Director was informed that that policy was not in the regulations, the Executive Director stated, "Oh, so they can have it." The Executive Director stated, "We have always been told that by our legal team." 4) Observation on at 12:00 PM the accessible phone to residents on the 7th floor was not working and did not have a dial tone. Interviewed on at 1:16 PM the Administrator did not provide any comments and remained silent. Class II	A 030		

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A 031	Continued From page 17	A 031		
A 031 SS=F	59A-36.007(6) FAC Resident Care - Third Party Services (6) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, , and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the , resident's needs. (c) The administrator or designee must ensure that: 1. Care coordination includes documented communications about the resident's condition and response to treatment or services ordered by the physician which may impact the resident's appropriateness for continued residency in the facility; 2. Communications occur at least once every 30 days and whenever there is a significant change	A 031		

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A 031	Continued From page 18 in the resident's condition; and 3. If physician ordered treatments or services occur less often than once a month, communications must be conducted according to the ordered treatment or service schedule and whenever there is a significant change in the resident's condition. 4. When communication with the third party provider is unsuccessful, at least two attempts at communication on two separate days must be documented. Documentation must include the name of the person from the third party provider with whom contact was attempted, the method of communication, and the date and time of the attempts. This documentation must be included in the resident's record in accordance with the timeframes in subparagraphs 59A-36.007(6)(c)2. and 3. (d) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that residents had the choice to self select the pharmacy they wanted to use for their prescription services. Findings: Record review of resident records revealed that in the contract section, residents were asked to	A 031		

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A 031	Continued From page 19 complete a document "Preferred Pharmacy for Mediction management with Belmont Village." Record review revealed that the Facility selected a preferred pharmacy for resident prescriptions and medication. Record review revealed that if residents opted to use their own pharmacy, they would be charged an additional fee. Class III	A 031		
A 033 SS=D	59A-36.007(8) PHYSICAL (8) PHYSICAL . Residents for whom a physician has prescribed a physical must have a written care plan for the use of the physical . The care plan must be developed within 14 days of the device being prescribed, and prior to use on the resident. (a) The care plan must specify: 1. The device prescribed for use; 2. The maximum amount of time the resident is to have the applied each day; and, 3. In what manner and frequency staff will monitor, observe, and report to the physician any injuries, increase in agitation, signs and symptoms of , , or decline in mobility or function related to the use of the prescribed . (b) Facility staff must ensure that the device is applied appropriately and safely. (c) The resident's physician must review the appropriateness of the continued use of the physical annually, and documentation of this review must be maintained in the resident's record. If the resident's ability to independently remove or avoid the device fluctuates, the device	A 033		

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A 033	Continued From page 20 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 that there was a written order, consent, and care plan for the use of a physical for one out of 15 sampled residents (#1). Findings included: Observation on at 7:27 am showed Resident # 1 was in bed sleeping with half bed rails on both sides of the bed. At the lowered part of bed where there was no bed rail, there as a bench with a pillow at the of the bed. The bench was about three by two and at the of the bed. The bench prevented the resident from exiting bed without staff assistance. During an interview on at 7:29 am Staff E (caregiver) stated that she did not know why the resident put the bench there, when asked about the bench. Staff E further stated that she assumed that she liked the bench there so that she can get out of her bed easier. Staff E said that she knew that Resident # 1 and broke her , but did not know the exact details because this happened before she'd started working at the facility. A review of Resident #1's health assessment dated showed that she had a diagnoses of hematoma, , , and , Resident #1 needed and , precautions and needed assistance with ambulation, bathing, , grooming, toileting, transferring, and was independent with eating.	A 033		

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A 033	Continued From page 21 Resident #1 needed assistance with self-administration of medications. A review of the Resident # 1's progress notes showed that on the resident and was hospitalized and on returned to the facility from rehabilitation. A review of Resident #1's contract showed that there was a section labeled "no " which stated that the "community is not permitted to use on its residents and further stated that "if you are not comfortable with this type of environment, we suggest that you consider a higher level of care. A review of Resident #1's records showed that there was no order for bed rails, no consent for bed rails, or plan of care for the use of the . Class III	A 033		
A 034 SS=D	59A-36.007(9) ASSISTIVE DEVICES (9) ASSISTIVE DEVICES. Facilities are responsible for ensuring the safe usage of a resident's assistive devices. (a) The facility must have policies and procedures that include the requirements and methods for assessing the physical condition of assistive devices that may injure the resident and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device. (b) Documentation of each assistive device a resident uses must be included in the resident's record. (c) Direct care staff using assistive devices while	A 034		

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A 034	Continued From page 22 rendering personal services to residents must know how to operate and utilize the equipment. (d) All assistive devices must be clean, in good repair, and free of hazards. (e) The facility must encourage and allow the resident to function with independence when using the assistive device. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the safe usage of assistive devices for one out of 15 sampled residents (#1). Findings included: Observation on at 7:27am showed Resident # 1 was in bed sleeping with half bed rails on both sides of the bed. A stand assist patient transport was observed by the window. (photographic evidence obtained) During an interview on at 7:29am Staff E (caregiver) stated that she did not know what the 'stand assist' was because she usually did not work on that floor. According to Ergonomics Health, "Sit to stand lifts are designed to assist a person in both standing but also in moving short distances." A review of the Resident # 1's progress notes showed that on resident and was hospitalized and on returned to the facility from rehabilitation. A review of Resident #1's health assessment dated showed that she had a diagnosis hematoma, , , . Resident	A 034		

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A	Continued From page 23 #1 had and precautions and needed assistance with ambulation, bathing, , grooming, toileting, transferring, and was independent with eating. Resident #1 needed assistance with self-administration of medications. There was no mention of an assisted device in the document. A review of the resident records showed that there was no physician order or documentation for the use of the stand assist device. A review of the facility's policy regarding assistive devices showed that 'each device used should be documented in the resident record; staff should be familiar with how to safely operate to assisted device; the director of resident care will schedule training on the device; staff shall ensure the device is clean and in good repair each time assistance is rendered; staff shall observed the use of the device and report any concerns.' Class III	A 034		
A 036 SS=D	59A-36.007(10) CONTROL PROCEDURES (10) CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of . (a) The facility must implement a hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or hygiene may include the use of -based rubs, , handwash, or handwashing with soap and water.	A 036		

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A 036	Continued From page 24 (b) Standard precautions must be used when there is an , exposure to transmissible agents in , , , , nonintact skin, and mucuous during the provision of personal services. Standard precautions include: hygiene, and dependent upon the exposure, use of gloves, gown, mask, , protection, or a shield. (c) The facility must clean and reusable medical equipment and communal assistive devices that have been designed for use by multiple residents before and after each use according to the manufacturer's recommendations. This Statute or Rule is not met as evidenced by: Based on observation and record review, the facility failed to ensure that staff implemented hygiene practices and standard precautions as demonstrated in their control guidelines and procedures for one out of fifteen sampled residents (Resident #12). Findings included: Observations on at 7:08 AM revealed that Staff T (Licensed Practical Nurse) removed Resident #12's pill from a medication cup and administered medication to Resident #12. Further observation revealed that Staff T didn't wash or prior to giving medication. A review of the facility's prevention and control guidelines revealed that the facility policy stated all staff and visitors are expected to practice good hygiene, including frequent handwashing with soap and water and the use of an -based sanitizer.	A 036		

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A 036	Continued From page 25 Class III	A 036		
A 052 SS=E	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this	A 052		

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A 052	Continued From page 26 section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described	A 052		

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A 052	Continued From page 27 in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed:	A 052		

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A 052	Continued From page 28 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation and record review, the facility failed to ensure that staff verbally informed residents of medications name and dosage for four out of fifteen sampled residents (Resident #5, #12, #13, #14). Findings include: 1. Observation on at 7:03 AM revealed Staff T (Licensed Practical Nurse)	A 052		

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A 052	Continued From page 29 administered Resident #5's medications without confirming the medication name and dosage. A review of Resident #5's health assessment dated showed the resident needed assistance with self-administration of medications. Observation on at 7:04 AM revealed Staff T administered Resident #12's medications without confirming the medication name and dosage. Observation on at 7:06 AM revealed that Staff T administered Resident #13's medications without confirming the medication name and dosage. A review of Resident #13's health assessment dated revealed, "patient with meds she takes." A review of Resident #13's health assessment showed the resident needed assistance with self-administration of medications. Observation on at 7:11 AM revealed that Staff T administered Resident #14's medications without confirming the medication name and dosage. Class III	A 052		
A 054 SS=E	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer	A 054		

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A 054	Continued From page 30 managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known ␣ the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to update the MOR (Medication Observation Record) immediately when assisting four out of fifteen sampled residents (Resident #5, #12, #13, #14) with self-administration of medications. Findings include:	A 054		

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A 054	Continued From page 31 Observation on from 7:03 AM to 7:11 AM , during assistance with self-administration of medication, it was observed that Staff T (Licensed Practical Nurse) handed Residents #5, #12, #13, #14 their medications. Staff T updated the MOR before the residents took their medications. During an interview on at 7:04 AM Staff T stated her shift was from 6:30 a.m. to 3:00 p.m. and she started on . When asked if she had received medication training, she stated yes. During an interview on at 1:16 PM Staff B acknowledged that Staff T updated the MOR before the medications were given to the residents. Class III	A 054		
A 055 SS=I	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter	A 055		

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A 055	Continued From page 32 medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other	A 055		

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A 055	Continued From page 33 residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure that staff kept centrally stored medications locked. Findings include:	A 055		

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A 055	Continued From page 34 On at 6:08 am, observation revealed the Office Manager left the Wellness Center door unlocked to go and find the nurse who was on duty. On at 6:41 AM: Observed a bag containing multiple medications in the corner behind the desk . On12/09/2025 at 7:14 AM: Observed unlocked stored medications in refrigerator. On at 7:23 AM: Observed unlocked cabinets underneath sink with two brown paper bags filled with multiple residents medications. During an interview on at 7:26 a.m. when asked about how medication was stored, who organized and oversaw the medications. Staff #C verbalized Staff #R was her assistant who helped her oversee the medication room. During an interview on at 10:36 a.m. when asked about unlocked medication observed in the Wellness room. Staff R acknowledged the observation that medications were found unsecured in the Wellness room. When asked about the medication in the cabinet under the sink, Staff R stated that the medications were recently reviewed by the pharmacy. She further stated that the facility's Pharmacy went through all medications and removed the medications of past cycles, expired, and discontinued medications. The medications are to be destroyed. When asked about the unlocked medication in the front drawer. Staff #R stated that the drawer was usually kept locked and she did not know why it was unlocked. Staff #R stated that the medications were expired and	A 055		

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A 055	Continued From page 35 were waiting to be destroyed. Class III	A 055		
A 077 SS=D	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is	A 077		

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A 077	Continued From page 36 responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least ; 2. If employed on or after , have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to , are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core	A 077		

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A 077	Continued From page 37 competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No	A 077		

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A 077	Continued From page 38 =Ref-09393. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that it was under the supervision of an Administrator who ensured and the provision of appropriate care of all residents. The Administrator failed to ensure the implementation of a intervention plan for Resident #1 after multiple undocumented . The Administrator also failed to conduct a thorough investigation after Resident #2 was found and slept in his wheelchair for more than 12 hours in the same clothes from the previous day in the memory care. The Administrator failed to schedule adequate staffing to accommodate residents in the assisted living and a qualified Director of Resident Care in making critical decisions involving resident care. The Administrator failed to ensure that employees were effectively trained regarding , and ( ), including the emergency evacuation plans and procedures. The administrator failed to file adverse incidents and respect the rights of residents, which were citations previously cited for a complaint investigation. Findings: 1) A review of the adverse incidents reporting systems database found no reported of Resident #1 falling on , which resulted in a and a on , resulting in a . A review of the Resident #1's records found no	A 077		

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A 077	Continued From page 39 intervention plan in after the first on . 2) A review of Resident #2's progress notes documented that the resident had to on his on in the morning. However, there was no investigation on how the resident injured himself and how the resident was found that morning in his wheelchair wearing the same clothes the day before ( ) and was not provided bath. Interviewed on at 12:46 PM the Administrator stated that she assigned Personal Assistant Alison (PAL) to the independent living residents to take out the garbage rather than to use housekeeping staff to do. The Administrator stated further that she did not know how many residents were in the assisted living facility and had to retrieve the information. A review of the Administrator's personnel records showed that the Administrator was a registered nurse in the state of Florida and a completion of the required core Assisted Living Facility administrator training on . 3) Interviewed on at 7:31 AM the Chef was unable to describe what the fixed generator would power in the kitchen in the event of a power outage and Staff L (PAL) stated at 6:51 AM if she found a resident unresponsive, she would call the nurse and wait for her. Furthermore, a review of the Level 2 Background Screening Clearinghouse showed the Director of Resident Care was hired without being placed on the roster and an eligible background check, including a valid license to practice nursing in the state of	A 077		

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	AL11970300	A. BUILDING: _____ B. WING _____	12/09/2025

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A 077	Continued From page 40 Florida. Interviewed on at 11:35 AM the Director of Resident Care stated that both residents (Residents #4 and #16) could take their own medicines themselves. When asked how she knew that both residents were able to self-administer their own medications, the Director of Resident Care stated that she had conducted an assessment on the residences to check their ability to administer their own medications. When asked if she was a physician, the Director of Resident Care stated, "No." The Director of Resident Care stated further that she made these assessments without the consultation of a physician. However, a review of the Director of Care personnel records found no valid license from the state of Florida to practice as a nurse or physician. Interviewed on at 1:16 PM the Executive Director did not make any comments regarding the Administrator's failure to ensure residents' safety. Class III	A 077		
A 079 SS=D	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	A 079		

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A 079	Continued From page 41	A 079		

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 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

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A 079	Continued From page 42 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 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.	A 079		

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A 079	Continued From page 43 (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 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	A 079		

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A 079	Continued From page 44 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, record review and interviews, the facility failed to ensure sufficient and adequate staffing was available to meet the schedule and unscheduled residents'. The facility only had five employees (Staff E, J, K, T, and U) assigned to care for 160 residents overnight. Findings: A review of the Staffing Pattern dated from10:30 PM-6:45 AM showed Staff E, J, K, T, V and W (Personal Assistant Liaisons) on schedule assigned to the assisted living and independent living residents, which totaled 160 residents. Photographic evidence obtained. Observation on at 6:06 AM found only five direct care employees in the facility, including two employees (Staff K PAL & Staff T PAL) assigned to memory care floor leaving only three employees (Staff E PAL, Staff K PAL, and Staff U License Practicing Nurse) to supervise and assist the remaining residents.	A 079		

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A 079	Continued From page 45 Interviewed on at 12:46 PM When asked the census of the ALF, the Administrator stated, "I don't know the total number from the top of my ." The Administrator later returned and stated that there were 100 assisted living residents and 60 independent living residents. A review of the staffing pattern for from 6:30 AM-2:45 PM showed PAL employees assigned to the Personal Assistant Laison employees were also assigned also to the independent living (IL) residents house more than 60 IL residents. Interviewed on at 7:15 AM Staff M (PALS) stated, "I picked up this morning shift." Staff M stated, "Sometimes, we are short staff. The mornings usually have short staff. This was where I picked up extra shifts." Interviewed on at 9:56 AM the Staff Q (License Practicing Nurse) stated, "I know in the memory care they would only staff three people. There was a staff shortage. I think we have a staff shortage because we have to do the memory care, assist as a nurse, the assisted living, and the independent residents." When asked why they have to assist the independent residents, Staff Q stated, "When they (independent living residents) are not feeling well, we have to provide care. A lot of them mismanage their medications. There was a resident who moved in two months ago. He had possession of his own medications; they took away from him and now he is taking his own medications again. Another resident took his own medication. It was taken away and now he is doing it again. There were normally LPNs per shift, 7 PALS to cover the ALF and IL, 3 PALs on the memory care floor. There were always call	A 079		

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A 079	Continued From page 46 outs. The 2nd shift was under staff. Two days ago ( ) there were only two PALs/CNAs on the second shift. Interviewed on at 1:16 PM the Administrator did not make any comments regarding insufficient staffing found on the overnight shift on . Class III	A 079		
A 160 SS=D	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a , ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission	A 160		

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A 160	Continued From page 47 of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to Rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in Rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in Rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by Section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 59A-36.007, F.A.C. (j) All food service records required in Rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's	A 160		

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A 160	Continued From page 48 license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.435, F.S., and rule Chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.; (q) The facility's prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.; (w) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain an updated admissions and discharge log for five (#7, #8, #9, #10, #11) out of 16 sampled residents.	A 160		

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A 160	Continued From page 49 Findings: 1) Interviewed on at 10:16 AM the Executive Director stated that Resident #7 on . A review of the admissions and discharge log showed Resident #7 was never discharged. 2) A review of the admissions and discharge log for Resident #8 showed a discharge on but no name of facility or home address to which the resident was discharged. 3) A review of the admissions and discharge log for Resident #9 showed a discharge on but no name of facility or home address to which the resident was discharged. 4) A review of the admissions and discharge log for Resident #10 showed a discharge on but no name of facility or home address to which the resident was discharged. 5) A review of the admissions and discharge log for Resident #11 showed a discharge on but no name of facility or home address to which the resident was discharged. Interviewed on at 1:16 PM the Administrator acknowledged that the admissions	A 160		

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A 160	Continued From page 50 and discharge log was not updated. Class III	A 160		
A 182 SS=D	59A-36.019(3) FAC Emergency Mgmt - Plan Implementation (3) PLAN IMPLEMENTATION. (a) All staff must be trained in their duties and are responsible for implementing the emergency management plan. New staff must be trained on the plan within 30 days of employment. (b) If telephone service is not available during an emergency, the facility must request assistance from local law enforcement or emergency management personnel in maintaining communication This Statute or Rule is not met as evidenced by: Based on interviews and record review, the facility failed to ensure that one of 22 staff sampled (Staff D) were adequately trained and prepared to implement the Emergency Evacuation Plan. Findings: A review of personnel files found that Staff D had been trained regarding the facility's Emergency Procedures. During an interview conducted on at 6:28 AM, Staff D stated she was unfamiliar with the protocol and procedures to follow in case of an emergency such as a tornado. Staff D indicated, "Well, I'll inform everybody on the floor," and described evacuating her floor's residents, but noted that second floor residents could evacuate independently.	A 182		

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A 182	Continued From page 51 Interviewed further on at 6:33 AM regarding the facility's Emergency Plan and when/how to evacuate the building if needed, Staff D stated, "I'll wait for the administrator's instructions," and referenced cameras and a speaking system for emergency communication, indicating reliance on administrative direction rather than established procedures. Class III	A 182		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of	A 078		

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A 078	Continued From page 52 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S.	A 078		

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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 078	Continued From page 53 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure five out of 22 sampled employees (Chef, Director of Resident Care, Staff F, Staff Q, & Staff L) were qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. in describing , ( ) and response to a choking victim, a ( ), and the emergency and evacuation and power outage plan. The facility failed to ensure the Director of Resident Care performed her duties and services which required a valid state license. The facility failed to ensure the Director of Resident Care was making decisions she was not qualified to do. The facility failed to ensure the Director of Resident Care and Staff F (Personal Assistant Laison) maintained evidence of a negative examination documentation on an annual basis. The facility failed to ensure Staff F had three (3) hours of Activities of Daily Living and Behavioral Needs training. Findings: 1) Interviewed on at 9:56 AM Staff Q (Licensed Practicing Nurse) stated that the Director of Resident Care was not qualified, and she did not do anything. Staff Q stated, the Director of Resident Care makes decisions in adjusting residents' Montreal Assessment (MOCA) test. I have seen her move people (residents) to manage their medications. A review of the Director of Resident Care's personnel records found no valid state license to	A 078		

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	AL11970300	A. BUILDING: _____ B. WING _____	12/09/2025

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A 078	Continued From page 54 practice nursing in the state of Florida. According to the MOCA site, one administering the test must be certified. The MOCA test is a test to quickly and accurately test subjects for mild irrespective of . A review of the Director of Resident Care found no documentation of any certifications to administer the MOCA test including a valid nursing license. Observation on at 7:40 AM found a pill organizer on the kitchen table along with pill bottles in occupied by Residents #4 and #16. Interviewed on at 11:35 AM the Director of Resident Care stated that both residents (Residents #4 and #16) can take their own medicines themselves. When asked how she knew that both residents were able to self-administer their own medications, the Director of Resident Care stated that she had conducted an assessment on the residences to check their ability to administer their own medications. When asked if she was a physician, the Director of Resident Care stated, "No." The Director of Resident Care stated further that she made these assessments widely without the consultation of a physician. A review of Resident #4's health assessment dated showed the resident needed assistance with self-administration of medications. A review of Resident #16's health assessment dated showed a diagnoses of Mild	A 078		

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A 078	Continued From page 55 ( ). The status showed Mild . However, there was no medication observation record to determine if the resident was consistent with taking her medications. Interviewed on at 11:45 AM the Private Personal Assistant Laison stated that the daughter of Residents #4 and #16 comes to give them their medications. Interviewed on at 12:04 PM when asked if the Director of Resident Care had a valid Florida license to practice nursing, the Administrator stated, "She was getting it now." 2) Interviewed on at 6:31 AM when asked about the evacuation plan in the event of a fire, if there was a fire Staff E (Personal Assistant Laison) stated that she was going to get a chair and move everyone away from the fire. 3) Interviewed on at 6:51 AM Staff L (PAL) stated that she worked from 6:30 AM-2:35 PM on the memory care floor. She stated that two people worked on the memory care and that she was employed for over two years. When asked to describe a , Staff L stated that she would call the nurse. Staff L stated that if a resident was unresponsive, she stated that she would pull the cord. Staff L stated further, "I would call the nurse and wait for the nurse. We have it on our work phones. I think we not supposed to do anything." When asked to describe , Staff L stated that she was not sure. When asked to describe how to handle a choking victim, Staff L stated that she would hold her up and	A 078		

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A 078	Continued From page 56 call the nurse. 4) Interviewed on at 7:15 AM Staff M (PAL) stated that she was a caregiver. Staff M stated, "I picked up this morning shift." Staff M stated, "I worked the memory care floors from 2:30 PM to 10:45 PM." When asked to describe a and what was, Staff M was unable to describe them. When asked to describe what to do with a choking victim, Staff M was unable to describe what to do. 5) Interviewed on at 7:31 AM when asked to describe what the fixed generator powers in the kitchen in the event of a power outage, the Chef was unable to describe. A review of the Chef's personnel records showed a hire date on . 6) A review the personnel records for the Director of Resident Care and Staff F (Personal Assistant Laison) found no evidence of a negative examination documentation on an annual basis for either of them. 7) Observation on at 9:04 AM Staff F was on the sixth-floor supervising and assisting residents. A review of Staff F's personnel records found no three hours of activities of daily living and	A 078		

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A 078	Continued From page 57 Behavioral needs training to contact with residents needing supervision and assistance in an assisted living facility. Interviewed on at 1:16 PM the Administrator did not make any comments. According to the American Association, "For healthcare providers and those trained: conventional using , and -to- breathing at a ratio of 30:2 , -to-breaths." According to Florida Health, " is a form or patient identification device developed by the Department of Health to identify people who do not wish to be in the event of , , or ." According to the Cleveland Clinic states the following when dealing with a choking victim: "stand to the side and hit behind the person. Kneel if it's a small child. Lean the person slightly forward, use your nondominant to gently support the person's . This means if you're handed, use your left for support. Use the heel of your dominant to strike the area between their blades. This is called a blow or slap, Do up to five of these. Between each one, pause to see if the object has come out. If five blows aren't enough, do up to five adnominal thrusts. This is also called [thrust]. You make a fist with one and clasp your other around it. Place your between the person's belly button and cage and push inward and upward. Don't attempt this unless you're trained. If the person is still choking, repeat this sequence of five blows and five thrust until the object comes out or medical help arrives. It the person goes	A 078		

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A 078	Continued From page 58 at any point before help arrives, begin if you are able." Class III	A 078		
A 161 SS=D	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by Rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section 429.174, F.S., and Rule 59A-36.010, F.A.C.,	A 161		

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A 161	Continued From page 59 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity ␣ to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by Rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on Interview and Record Review, the facility failed to maintain a complete job description for 1 of 22 sampled staff members (Staff C). Findings included: During an interview conducted on at 6:35 AM, Staff C stated she was responsible for overseeing resident care, supervising medication pass, and performing internal facility health assessments. A Review of Staff C's employee file found no documentation of a contract, no documented job description on file, professional clinical license (authorizing health assessments and medication	A 161		

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A 161	Continued From page 60 administration), or training certificates. Class III	A 161		
A 165 SS=D	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 its personnel for investigation; or	A 165		

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A 165	Continued From page 61 (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 s. 456.073 apply.	A 165		

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A 165	Continued From page 62 (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 observation and record review, the facility failed to provide an adverse incident report to the Agency for Health Care Administration (AHCA) for one out of 15 sampled residents (#1). Findings Included: Observation on at 7:27 am showed Resident # 1 was in bed sleeping with half bed rails on both sides of the bed. A review of Resident # 1's progress notes showed that on resident and was hospitalized and returned to the facility from rehabilitation on after having a , resulting from a in the facility. Further review found no documentation that an incident report was filed. A review of facility records showed that the last adverse incident report filed was .	A 165		

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A 165	Continued From page 63 Class III	A 165		
AN278 SS=D	59A-36.022(3) FAC; 429.07(3)(c)2, FS LNS - Records 59A-36.022 (3) RECORDS. (a) A record of all residents receiving limited nursing services and the type of services provided must be maintained at the facility. (b) Nursing progress notes must be maintained for each resident who receives limited nursing services from facility staff. (c) A nursing assessment conducted at least monthly must be maintained on each resident who receives a limited nursing service. 429.07 (3)(c)2, FS A facility that is licensed to provide limited nursing services shall maintain a written progress report on each person who receives such nursing services from the facility's staff. The report must describe the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health... This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to maintain written progress notes, updated monthly, for 1 out of 15 sampled residents (Resident #6) who received Limited Nursing Services (LNS). Findings: On at approximately 9:00AM, interview of the Administrator revealed that there were four residents receiving LNS services. The	AN278		

Agency for Health Care Administration

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AN278	Continued From page 64 Administrator provided a list of those residents. Review of Resident #6's initial LNS progress note revealed that Resident #6 had a history of and diagnoses of , , , , , , , , . The resident had a . Further review of the record showed that the last progress note written was dated . Class III	AN278		

Agency for Health Care Administration

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ZZ815	408.809(1)( ); 435.02(2); 435.06 FS Background Screening; Prohibited Offenses 408.809 Background screening; prohibited offenses.- (1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are considered employees for the purposes of conducting screening under chapter 435: (a) The licensee, if an individual. (b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider. (c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider. (d) Any person who is a controlling interest. (e) Any person, as required by authorizing statutes, seeking employment with a licensee or provider who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, ␣ with a licensee or provider whose responsibilities require him or her to provide personal care or personal services directly to clients, or ␣ with a licensee or provider to work 20 hours a week or more who will have access to client funds, personal property, or living areas. Evidence of contractor screening may be retained by the contractor's employer or the licensee. (3) All ␣ , must be provided in electronic format. Screening results shall be reviewed by the agency with respect to the offenses specified in s. 435.04 and this section, and the qualifying or disqualifying status of the person named in the request shall be maintained in a database. The	ZZ815		

AHCA Form 3020-0001

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

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ZZ815	Continued From page 1	ZZ815		

qualifying or disqualifying status of the person named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee's behalf.

(4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction:
(a) Any authorizing statutes, if the offense was a felony.
(b) This chapter, if the offense was a felony.
(c) Section 409.920, relating to Medicaid provider fraud.
(d) Section 409.9201, relating to Medicaid fraud.
(e) Section 741.28, relating to domestic violence.
(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.
(g) Section 784.03, relating to battery, if the victim is a adult as defined in s. 415.102 or a patient or resident of a facility licensed under chapter 395, chapter 400, or chapter 429.
(h) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.
(i) Section 817.234, relating to false and fraudulent insurance claims.
(j) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.
(k) Section 817.50, relating to fraudulently

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ZZ815	Continued From page 2 obtaining goods or services from a health care provider. (l) Section 817.505, relating to patient brokering. (m) Section 817.568, relating to criminal use of personal identification information. (n) Section 817.60, relating to obtaining a credit card through fraudulent means. (o) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony. (p) Section 831.01, relating to forgery. (q) Section 831.02, relating to uttering forged instruments. (r) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes. (s) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes. (t) Section 831.30, relating to fraud in obtaining medicinal drugs. (u) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony. (v) Section 895.03, relating to racketeering and collection of unlawful debts. (w) Section 896.101, relating to the Florida Money Laundering Act. If, upon rescreening, a person who is currently employed or with a licensee and was screened and qualified under s. 435.04 has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible	ZZ815		

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	AL11970300	A. BUILDING: _____ B. WING _____	12/09/2025

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ZZ815	Continued From page 3 to apply for an exemption and the exemption request is received by the agency no later than 30 days after receipt of the rescreening results by the person. (5) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening. (6)(a) As provided in chapter 435, the agency may grant an exemption from disqualification to a person who is subject to this section and who: 1. Does not have an active professional license or certification from the Department of Health; or 2. Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification. (b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may grant an exemption from disqualification to a person who is subject to this section and who has received a professional license or certification from the Department of Health or a regulatory board within that department and that person is providing a service within the scope of his or her licensed or certified practice. (7) The agency and the Department of Health may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, chapter 435, and authorizing statutes requiring background screening and to implement and adopt criteria	ZZ815		

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ZZ815	Continued From page 4 relating to retaining ⌣ , pursuant to s. 943.05(2). (8) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this section, terminates the person against whom the report was issued, whether or not that person has filed for an exemption with the Department of Health or the agency. 435.06 Exclusion from employment.- (1) If an employer or agency has reasonable cause to believe that grounds exist for the denial or termination of employment of any employee as a result of background screening, it shall notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity. (2)(a) An employer may not hire, select, or otherwise allow an employee to have contact with any person that would place the employee in a role that requires background screening until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of employment. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select, or otherwise allow the employee to have contact with any person that would place the employee in a role that requires background screening unless the employee is granted an	ZZ815		

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ZZ815	Continued From page 5	ZZ815		

exemption for the disqualification by the agency as provided under s. 435.07.
(b) If an employer becomes aware that an employee has been for a disqualifying offense, the employer must remove the employee from contact with any person that places the employee in a role that requires background screening until the is resolved in a way that the employer determines that the employee is still eligible for employment under this chapter.
(c) The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of this chapter or place the employee in a position for which background screening is not required unless the employee is granted an exemption from disqualification pursuant to s. 435.07.
(d) An employer may hire an employee to a position that requires background screening before the employee completes the screening process for training and orientation purposes. However, the employee may not have direct contact with persons until the screening process is completed and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment.
(3) Any employee who refuses to cooperate in such screening or refuses to timely submit the information necessary to complete the screening, including , if required, must be disqualified for employment in such position or, if employed, must be dismissed.
(4) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages against, an employer that, upon notice of a conviction or for a disqualifying offense listed under this chapter,

Agency for Health Care Administration

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ZZ815	Continued From page 6 terminates the person against whom the report was issued or who was , regardless of whether or not that person has filed for an exemption pursuant to this chapter. 435.02 Definitions.-For the purposes of this chapter, the term: (2) "Employee" means any person required by law to be screened pursuant to this chapter, including, but not limited to, persons who are contractors, licensees, or volunteers. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that one of 22 sampled staff (Director of Resident Care Services) who had access to residents and who provided services had an eligible Level II background screening. Findings: Interviewed on at 8:30 AM, the Executive Director stated that the Director of Resident Care Services had a Level II background screening. The executive Director presented the document for review. A review of the document presented showed a date of birth that indicated an age of two years old for a person resembling the Director of Resident Care Services. The date of birth did not match that of the Director of Resident Care Services. Review of the background screening database revealed that two persons matched the name of Staff C in the general system. There was no documentation of an eligible level 2 background screening for the Director of Resident Care Services. On at 7:30 AM, Director of Resident	ZZ815		

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ZZ815	Continued From page 7 Care Services stated that she had been working at the facility for 3 months. Unclassified	ZZ815		

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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

Agency for Health Care Administration

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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 interview and record review, the facility failed to ensure that one of 22 sampled staff who had access to residents was listed on the facility's roster (Director of Resident Care Services). Findings: Review of the facility's staff roster in the Clearinghouse Screening Management System (CSMS) revealed that the appointed Director of Resident Care Services was not listed. On at 7:30 AM, Director of Resident Care Services stated that she had been working at the facility for 3 months . Unclassified	ZZ814		