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
	AL11967840	A. BUILDING: _____ B. WING _____	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADISE VILLA ALF, INC	21164 SW 92 PL CUTLER BAY, FL 33189

(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 200 SS=F	59A-36.025 FAC Emergency Environmental Control 59A-36.025 Emergency Environmental Control for Assisted Living Facilities. (1) DETAILED EMERGENCY ENVIRONMENTAL CONTROL PLAN. Each assisted living facility shall prepare a detailed plan ("plan") to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency environmental control in the event of the loss of primary electrical power in that assisted living facility which includes the following information: (a) The acquisition of a sufficient alternate power source such as a generator(s), maintained at the assisted living facility, to ensure that current licensees of assisted living facilities will be equipped to ensure air temperatures will be maintained at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. 1. The required temperature must be maintained in an area or areas, determined by the assisted living facility, of sufficient size to maintain residents safely at all times and that is appropriate for resident care needs and life safety requirements. For planning purposes, no less than twenty (20) net square per resident must be provided. The assisted living facility may use eighty percent (80%) of its licensed bed capacity as the number of residents to be used in the to determine the required square footage. This may include areas that are less than the entire assisted living facility if the assisted living facility's comprehensive emergency management plan includes allowing a resident to congregate when he or she desires in portions of the building where temperatures will be maintained and includes procedures for monitoring residents for signs of heat related injury as required by this rule. This rule does not	A 200		

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prohibit a facility from acting as a receiving provider for evacuees when the conditions stated in Section 408.821, F.S. and subsection 59A-36.019(5), F.A.C., are met. The plan shall include information regarding the area(s) within the assisted living facility where the required temperature will be maintained.
2. The alternate power source and fuel supply shall be located in an area(s) in accordance with local zoning and the Florida Building Code.
3. Each assisted living facility is unique in size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and staffing characteristics. Accordingly, this rule does not limit the types of systems or equipment that may be used to achieve temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. The plan shall include information regarding the systems and equipment that will be used by the assisted living facility and the fuel required to operate the systems and equipment.
a. An assisted living facility in an evacuation zone pursuant to Chapter 252, F, S. must maintain an alternative power source and fuel as required by this subsection at all times when the assisted living facility is occupied but is permitted to utilize a mobile generator(s) to enable portability if evacuation is necessary.
b. Assisted living facilities located on a single campus with other facilities under common ownership, may share fuel, alternative power resources, and resident space available on the campus if such resources are sufficient to support the requirements of each facility's residents, as specified in this rule. Details regarding how resources will be shared and any

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necessary movement of residents must be clearly described in the emergency power plan.
c. A multistory facility, whose comprehensive emergency management plan is to move residents to a higher floor during a flood or surge event, must place its alternative power source and all necessary additional equipment so it can safely operate in a location protected from flooding or storm surge damage.
(b) The acquisition of sufficient fuel, and safe maintenance of that fuel at the facility, to ensure that in the event of the loss of primary electrical power there is sufficient fuel available for the alternate power source to maintain temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours after the loss of primary electrical power during a declared state of emergency. The plan must include information regarding fuel source and fuel storage.
1. Facilities must store minimum amounts of fuel onsite as follows:
a. A facility with a licensed capacity of 16 beds or less must store 48 hours of fuel onsite.
b. A facility with a licensed capacity of 17 or more beds must store 72 hours of fuel onsite.
2. An assisted living facility located in an area in a declared state of emergency area pursuant to Section 252.36, F.S. that may impact primary power delivery must secure ninety-six (96) hours of fuel. The assisted living facility may utilize portable fuel storage containers for the remaining fuel necessary for ninety-six (96) hours during the period of a declared state of emergency.
3. Piped natural gas is an allowable fuel source and meets the onsite fuel supply requirements under this rule.
4. If local ordinances or other regulations limit the amount of onsite fuel storage for the assisted

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A 200	Continued From page 3 living facility's location, then the assisted living facility must develop a plan that includes maximum onsite fuel storage allowable by the ordinance or regulation and a reliable method to obtain the maximum additional fuel at least 24 hours prior to depletion of onsite fuel. (c) The acquisition of services necessary to maintain, and test the equipment and its functions to ensure the safe and sufficient operation of the alternate power source maintained at the assisted living facility. (d) The acquisition and maintenance of a monoxide alarm. (2) SUBMISSION OF THE PLAN. (a) Each new assisted living facility shall submit the plan required under this rule prior to obtaining a license. (b) Each existing assisted living facility that undergoes any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of its systems or equipment affecting the facility's compliance with this rule shall amend its plan and submit it to the county emergency management agency for review and approval. (3) APPROVED PLANS. (a) Each assisted living facility must maintain a copy of its approved plan in a manner that makes the plan readily available at the licensee's physical address for review by a legally authorized entity. If the plan is maintained in an electronic format, assisted living facility staff must be readily available to access and produce the plan. For purposes of this section, "readily available" means the ability to immediately produce the plan, either in electronic or paper format, upon request. (b) Within 30 days of the approval of the plan from the county emergency management agency,	A 200		

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A 200	Continued From page 4 the assisted living facility shall submit in writing proof of the approval to the Agency for Health Care Administration to assistedliving@ahca.myflorida.com. (c) The assisted living facility shall submit a consumer-friendly summary of the emergency power plan to the Agency. The Agency shall post the summary and notice of the approval and implementation of the assisted living facility emergency power plans on its website within ten (10) business days of the plan's approval by the county emergency management agency and update within ten (10) business days of implementation. (4) IMPLEMENTATION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall, no later than . , have implemented the plan required under this rule. (b) Each new assisted living facility shall implement the plan required under this rule prior to obtaining a license. (c) Existing assisted living facilities that undergo any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of the systems or equipment affecting the assisted living facility's compliance with this rule shall implement its amended plan concurrent with any such additions, modifications, alterations, refurbishment, renovations or reconstruction. (5) POLICIES AND PROCEDURES. (a) Each assisted living facility shall develop and implement written policies and procedures to ensure that the assisted living facility can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. The procedures shall ensure that	A 200		

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A 200	Continued From page 5 residents do not experience complications from fluctuations in air temperatures inside the facility. Procedures must address the care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury including: 1. The use of cooling devices and equipment; 2. The use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration; 3. Wellness checks by assisted living facility staff to monitor for signs of , and heat injury; and 4. A provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy. (b) Each assisted living facility shall maintain the written policies and procedures in a manner that makes them readily available at the licensee's physical address for review by a legally authorized entity. If the policies and procedures are maintained in an electronic format, assisted living facility staff must be readily available to access the policies and procedures and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce the policies and procedures, either in electronic or paper format, upon request. (c) The written policies and procedures must be readily available for inspection by each resident; each resident's legal representative, designee, surrogate, guardian, attorney in fact, or case manager; each resident's estate; and such additional parties as authorized in writing or by law. (6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this rule, the Agency for Health Care Administration	A 200		

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A 200	Continued From page 6 may seek any remedy authorized by Chapter 429, Part I, or Chapter 408, Part II, F.S., including, but not limited to, license revocation, license suspension, and the imposition of administrative fines. (7) COMPREHENSIVE EMERGENCY MANAGEMENT PLAN. (a) Assisted living facilities whose comprehensive emergency management plan is to evacuate must comply with this rule. (b) Each facility whose plan has been approved shall submit the plan as an addendum with any future submissions for approval of its comprehensive emergency management plan. (8) NOTIFICATION. (a) Within five (5) business days, each assisted living facility must notify in writing, unless permission for electronic communication has been granted, each resident and the resident's legal representative: 1. Upon the initial submission of the plan to the county emergency management agency that the plan has been submitted for review and approval; 2. Upon final implementation of the plan by the assisted living facility. 3. Annual submissions and approvals of the plan do not require notification to residents or their legal representatives unless a significant modification as defined in Rule 59A-36.019, F.A.C., has been made to the plan. (b) Each assisted living facility must maintain a copy of each notification set forth in paragraph (a) above in a manner that makes each notification readily available at the licensee's physical address for review by a legally authorized entity. If the notifications are maintained in an electronic format, facility staff must be readily available to access and produce the notifications. For purposes of this section, "readily available"	A 200		

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A 200	Continued From page 7 means the ability to immediately produce the notifications, either in electronic or paper format, upon request. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to have a working emergency power generator able to maintain temperatures at or below 81 degrees in case of the loss of primary power. Findings included: Observation on at 10:50 AM showed that Staff C and Staff B attempted to start the portable generator for several minutes, but the generator would not start. Further observation showed that the Administrator later joined Staff B and Staff C trying to start the generator, but the generator would not start. The generator never started. Interviewed on at 11:10 AM the Administrator stated that the generator would not start because the battery was . Class III	A 200		
AL243 SS=D	429.075(1) FS; 59A-36.011(9) FAC LMH - Training 429.075 (1) To obtain a limited mental health license, a facility must hold a standard license as an assisted living facility, must not have any current uncorrected violations, and must ensure that, within 6 months after receiving a limited mental health license, the facility administrator and the staff of the facility who are in direct contact with	AL243		

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mental health residents must complete training of no less than 6 hours related to their duties. This designation may be made at the time of initial licensure or relicensure or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with this part, part II of chapter 408, and applicable rules. This training must be provided by or approved by the Department of Children and Families.

59A-36.011
(9) LIMITED MENTAL HEALTH TRAINING.
(a) Pursuant to section 429.075, F.S., the administrator, managers and staff, who have direct contact with mental health residents in a licensed limited mental health facility, must receive the following training:
1. A minimum of 6 hours of specialized training in working with individuals with mental health diagnoses.
a. The training must be provided or approved by the Department of Children and Families and must be taken within 6 months of the facility's receiving a limited mental health license or within 6 months of employment in a limited mental health facility.
b. Training received under this subparagraph may count once for 6 of the 12 hours of continuing education required for administrators and managers pursuant to section 429.52(5), F.S., and subsection (1) of this rule.
2. A minimum of 3 hours of continuing education, which may be provided by the ALF administrator, online, or through distance learning, biennially thereafter in subjects dealing with one or more of the following topics:
a. Mental health diagnoses; and,
b. Mental health treatment such as:

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AL243	Continued From page 9 (I) Mental health needs, services, behaviors and appropriate interventions; (II) Resident progress in achieving treatment goals; (III) How to recognize changes in the resident's status or condition that may affect other services received or may require intervention; and, ( ) Crisis services and the procedures. 3. For administrators and managers, the continuing education requirement under this subsection will satisfy 3 of the 12 hours of continuing education required biennially pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 4. Administrators, managers and direct contact staff affected by the continuing education requirement under this subsection shall have up to 6 months after the effective date of this rule to meet the training requirement. (b) Administrators, managers and staff do not have to repeat the initial training should they change employers provided they present a copy of their training certificate to the current employer for retention in the facility's personnel files. They must also ensure that copies of the continuing education training certificates, pursuant to subparagraph (a)2. of this subsection, are retained in their personnel files. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation for the completion of Limited Mental Health (LMH) training for 1 out of 3 sampled staff (C). Findings included: A review of Florida Health Finders showed the	AL243		

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AL243	Continued From page 10 facility had a Limited Mental Health (LMH) Specialty License. A review of Staff C's record revealed a hire date of . Further review of Staff C's record showed no documentation for the completion of 6 hours of LMH training. Interviewed on at 1:55 PM, the Administrator stated that she would ensure Staff C received the required training. Class III	AL243		

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A 078 SS=K	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 . 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	A 078		

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A 078	Continued From page 1	A 078		

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.

This Statute or Rule is not met as evidenced by:
Based on observation, record review and interviews, the facility failed to ensure staff were qualified and performed their duties according to their training and preparation for one of seven sampled residents (Resident 1). Resident 1 , stopped breathing, and staff did not call rescue or perform (, ,). Resident 1 at the hospital.

Findings included:

A review of Resident 1's hospital records dated revealed that Resident 1arrived at the Emergency Department via rescue, in

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. Further review of the hospital record showed, "As per rescue patient was in his ALF [assisted living facility] just finished his lunch when people around him noticed patient slumped forward, falling from his wheelchair unresponsive, hit his frontal area on the process. Per rescue when they arrived nobody was doing on patient, noticed he was [,] and was initiated at that time." Further review of the hospital record showed Resident 1 was admitted to [ ] with diagnoses of , , , , , , , and , . Additional review revealed that Resident 1 expired at the hospital on .

Interviewed on at 1:05 PM Staff B (Caregiver), stated that was not initiated at the facility until emergency medical services arrived. Staff B stated, "[Resident 1] on the floor with his wheelchair in the dining room. I am not sure who called 911. No, I did not do . I never did it. Rescue did it."

Interviewed on at 1:15 PM Staff C (Caregiver), stated that she never administered to Resident 1. Staff C further stated that when Resident 1 to the floor and stopped breathing she panicked, didn't know what to do and a visitor at the facility called 911. Staff C stated," No, I did not give him . Rescue did that. I panicked, I don't know who called 911, I think [another resident's] family member called 911, she told us what to do, I was very nervous."

Interviewed on at 10:41 AM Resident 4's daughter stated that on she was at the facility visiting her mother when she observed that Resident 1 was in his wheelchair after finishing his lunch and he appeared to be

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PARADISE VILLA ALF, INC	21164 SW 92 PL CUTLER BAY, FL 33189

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A 078	Continued From page 3 resting when the Resident to the floor with his wheelchair. Resident 4's daughter further stated that she called 911 and she was asked if Resident 1 was breathing and stated she believed that he was not. Resident 4's daughter further stated that police and rescue arrived and was started by Emergency Medical Services at that point. A review of the staffing schedule showed that Staff B and Staff C were the only caregivers employed at the facility. Observation on at 6:00 AM revealed that Staff B was working alone and Residents 2, 3, 4, 5 and 6 were at the facility. Observation on at 7:00 AM showed that Staff C arrived with Participant #7. A review of resident and participant records revealed no or other documentation indicating that residents 2, 5, 6, or day care participant 7 did not want to be if they became unresponsive. A review of the National Library of Medicine's Medical Encyclopedia showed, "A do-not- order, or order, is a medical order written by a health care provider. It instructs providers not to do if a patient's breathing stops or if the patient's stops beating." Further review showed that was described as, "the treatment you receive when your flow or breathing stops. It may involve: " Simple efforts such as -to-breathing and pressing on the " Electric to restart the " to open the airway	A 078		

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A 078	Continued From page 4 " Medicines". Interviewed on at 1:05 PM Staff B (Caregiver), when asked to describe , she stated that she wasn't sure how to. Staff B stated she would give, "3 presses" and pointed to her . She stated, "I don't remember well. Yes, I have training." A review of Staff B's record showed documentation for training completed in and valid through . Interviewed on at 1:15 PM when asked to describe , Staff C was unable to. Staff C stated, "I would give 3 presses. Yes, I have training." A review of Staff 's C personnel record showed documentation for training completed in and valid through . Interviewed on at 1:55 PM the Administrator confirmed that Staff B and Staff C had received training. According to the American Association, "For healthcare providers and those trained: conventional using , and -to- breathing at a ratio of 30:2 , -to-breaths." A review of the Bill of Rights found in all resident and participant records showed, 'A patient has the right to receive treatment for any medical condition that will deteriorate from failure to provide treatment." Class I	A 078		

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A 000	Continued From page 5	A 000		
A 000	Initial Comments A re-certification survey was conducted at Paradise Villa ALF from through . Class 1 deficiencies were found at tags A 025, A 078. A Class 1 deficiency is a deficiency that the Agency determines presents a situation in which immediate corrective action is necessary because the facility's non-compliance has caused, or is likely to cause, serious injury, harm, , or to a resident receiving care in a facility. The Class 1 non-compliance began on . The facility Administrator was notified of the Class 1 non-compliance on The census at the start of the survey was 5 residents. The following is a description of the deficiencies found at the time of the visit: A 025, A 032, A 052, A 053, A 054, A 078, A 162, ZC816.	A 000		
A 025 SS=J	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	A 025		

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A 025	Continued From page 6 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 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	A 025		

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A 025	Continued From page 7 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, record review and interview, the facility failed to provide adequate supervision and follow its own policies and procedures for 3 out of 6 sampled residents that needed assistance, had and sustained serious injuries (2, 3, 4). Resident 2 while walking unassisted and sustained a , requiring surgery and rehabilitation. Resident 3 had an unwitnessed and sustained and , . Resident 4 had an unwitnessed and sustained a , . Findings included: 1) Observation on at 8:35 AM showed that Resident 2 was in the facility, walking with great difficulty and without assistance. The Resident was not using an assistive device. Further observation on at 8:43 AM showed that Resident 2 on the floor while walking from the patio to the family room without assistance. Further observation on at 9:12 AM showed that the Administrator and Staff C helped Resident 2 into a dining chair and later transferred her to a wheelchair. The Resident winced in , when the Administrator touched her left , .	A 025		

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A 025	Continued From page 8 Observation on at 9:55 AM showed that an ambulance transported Resident 2 to the hospital emergency room. A review of Resident 2's hospital record dated showed Resident 2 presented to the Emergency Department after a at her Assisted Living Facility (ALF) and was diagnosed with an angulated left , was admitted in guarded condition and placed in multimodal , management. Further review showed Resident 2 underwent left , intramedullary nail insertion and was transferred to rehabilitation on . According to the Orthopedic Association," An angulated is a specific type of , occurring between the greater and lesser of the often resulting from . The term angulated refers to the angle formed at the site which can affect the stability and healing process of the . Intramedullary nailing is a surgical technique used to stabilize of long bones inserting a metal rod called intramedullary nail into the medullar canal" A review of Resident 2's health assessment dated revealed diagnoses of gait instability, generalized , of the , , disuse , , , , , with , , a , and hypercholesteremia. Physical limitations showed the Resident needed human assistance to transfer and walk, diminished visual acuity, poor coordination and balance, used a walker for mobility and , . The status showed and severely . Nursing requirements showed as needed. Special	A 025		

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A 025	Continued From page 9 precautions showed precautions. The activities of daily living (ADL) showed the Resident needed assistance with toileting, self-care, bathing, , eating; showed independence with ambulation and transferring. The Resident needed assistance with self-administration of medication. Further review of Resident 2's record revealed physician's orders for a wheelchair with seatbelt dated . A review of Resident 2' s resident observation log dated showed," Today [Resident 2's] Primary Care Physician (PCP) ordered a transport wheelchair due to [Resident 2] shows more tiredness when walking long distances. Also, when she is sitting in the dining room she goes to her sides and we want to avoid " Interviewed on at 9:45 AM when she was asked why Resident 2 ambulating unassisted and was not using a wheelchair the Administrator stated, "She only uses the wheelchair when she gets tired. She doesn't use a walker. She can walk, with supervision" 2) A review of Resident 3's observation log dated revealed the Resident had an unwitnessed in her room while transferring from a commode to her bed, was transferred to the hospital with acute , in the right and was diagnosed with right , and . Interviewed on at 1:05 PM when asked about Resident 3's Staff B stated," I found her in her room, on the floor, she was in front of her bed. She got up to go to the	A 025		

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A 025	Continued From page 10	A 025		

bathroom. I heard she called for help and when I went, she had ".

A review of Resident 3's health assessment dated showed the Resident was and had diagnoses of closed of other parts of the , with routine healing, closed of with routine healing, closed of third and fourth generalized and . The Resident's physical limitations showed diminished visual acuity, poor coordination and balance, and the use of a walker for mobility. The status showed memory loss. Nursing requirements showed as needed. Special precautions showed precautions. The activities of daily living (ADL) showed the Resident needed assistance with ambulation, transferring, toileting, self-care, and bathing, supervision with eating. The Resident needed assistance with self-administration of medication.

A review of Resident 3's hospital discharge instructions dated revealed diagnoses of , abnormal diagnostic test, abnormal laboratory findings, elevated troponin level and high .

According to John Hopkins Medicine, " of the , or blade are most often caused by direct from the and symptoms include , and "

According to WebMD, " are usually caused when falling backwards on the tailbone, usually on a hard surface like the floor

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A 025	Continued From page 11 and can cause a lot of , and discomfort" 3) A review of Resident 4's record showed that Staff C found Resident 4 on the floor in front of her bedroom after the Resident called for help and the Resident was assisted to her . Further review showed the Resident was , could not remember how she and was complaining of , in her left , and was transferred to the hospital via ambulance where she was diagnosed with left , . A review of Resident 4's health assessment dated revealed diagnoses of , , a , , non- valve , of the (Diastolic), , high , , , of region, , veins of lower left extremity, , and generalized . Physical limitations showed diminished visual acuity, poor coordination and balance, , used a walker for mobility, and needed human assistance to walk. Nursing requirements showed as needed. status showed moderate . Special precautions showed precautions. The activities of daily living (ADL) showed the Resident needed assistance with ambulation, transferring, toileting, self-care, bathing, and , needed supervision with eating. The Resident needed assistance with self-administration of medication. A review of the facility's prevention policy revealed: "Policy: The Administrator, during working hours, and the staff members who are on duty are	A 025		

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A 025	Continued From page 12 responsible for supervision and support to the residents they serve" Procedure: 1) Review resident's health assessment (AHCA Form 1823) entirely and identify if the resident is at risk for Administrator is to share information on the form of a meeting with staff so they will be aware of resident's needs. 2) Identify if the resident has a prescription order indicating bedrail or assistive devices that aid in their mobility. Interventions: Inform all staff of residents' health care needs and how to use devices as prescribed" Class I	A 025		
A 032 SS=F	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response	A 032		

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A 032	Continued From page 13 policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement	A 032		

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A 032	Continued From page 14 drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain elopement response standards for 3 out of 3 sampled staff. The facility failed to conduct and provide documentation for resident elopement drills. Findings included: A review of facility and staff records showed no documentation for elopement response drills. When asked to provide documentation for the facility's elopement response drills Staff C called the Administrator and asked for instructions to find elopement drill logs but she could not find them. Interviewed on at 7:30 AM when asked if she had participated in an elopement drill Staff C stated, "No, I have not participated in an elopement drill, it's not going to happen here, they are not going to elope" Interviewed on at 7:35 AM when asked if she had participated in an elopement drill Staff B stated, "No, I have never participated in an elopement drill" Interviewed on at 7:45 AM when she was told Staff B and Staff C had stated that they had never participated in elopement drills the Administrator stated, "We have the logs, she just can't find them. [Staff B] educational level is very low, she probably thought the elopement drills were activities"	A 032		

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A 032	Continued From page 15 Class III	A 032		
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 section.	A 052		

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A 052	Continued From page 16 (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 in this section shall not be considered	A 052		

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A 052	Continued From page 17 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: 1. The health care provider may prescribe a	A 052		

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A 052	Continued From page 18 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 interview, the facility failed to follow the procedure outlined by the State when assisting residents with self-administration of medication for 2 out of seven sampled residents (4, 7). The facility failed to keep a record when the residents received assistance with self-administration of medication. Findings included: Observation on at 12:10 PM showed	A 052		

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A 052	Continued From page 19 that Staff C passed the medication , 25 MG tablets to Resident 4 at the dining table. Further observation showed that Staff C did not document the medication observation record (MOR) after offering the medication to Resident 4. Observation on at 12:14 PM showed that Staff C passed the medication , 2 MG to Resident 7 at the dining table. Further observation showed that Staff C did not document the MOR after offering the medication to Resident 7. A review of Resident 4 and Resident 7's medication observation record revealed that the medications were never documented (Photographic evidence obtained) Interviewed on Staff C stated that she forgot to sign the MOR after she passed the medications to the Residents. Class III	A 052		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer 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	A 054		

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A 054	Continued From page 20 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, record review and interview, the facility failed to maintain an up-to-date medication record for one out of seven sampled residents (5). The facility omitted to document that the Resident had missed a medication dosage. Findings included: Observation on at 12:20 PM showed that Staff C offered the medication , 50 MG ordered at 12:00 PM to Resident 5, but the Resident was unable to take the medication. Further observation showed that after several attempts Resident 5 was unable to take his medication Staff C stated, "I can't give it to him" and placed the discarded medication pill inside a	A 054		

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A 054	Continued From page 21 sharp waste container. A review of the medication observation record (MOR) revealed that staff C never documented Resident 5's missed medication dose. Interviewed on at 12:30 PM Staff C stated that she did not sign the MOR because Resident 5 did not take his medication. Class III	A 054		
A 162 SS=E	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or	A 162		

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A 162	Continued From page 22	A 162		

implemented by the facility that require a health care provider's order.
(d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable.
(e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C.
(f) A ˘ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their ˘ recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that ˘ not be taken.
(g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract.
(h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C.
(i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C.
(j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S.
(k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly

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A 162	Continued From page 23 written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be	A 162		

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A 162	Continued From page 24 provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided 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 observation, record review and interview, the facility failed to maintain an accurate health assessment for two out of seven sampled residents (2, 5). Resident 2 needed human assistance to ambulate and had orders for a wheelchair with seatbelt, but her health assessment indicated she was independent for ambulation and transferring. Resident 5 had a severe condition, needed medication administration but his health assessment indicated he needed assistance with self-administration of medication. Findings included: 2) Observation on at 8:35 AM showed that Resident 2 had difficulty walking unassisted from the family room to the patio. Observation on at 8:43 AM showed that Resident 2 on the floor while walking unassisted from the patio to the family room. A review of Resident 2's health assessment dated showed diagnoses of gait instability, generalized of the and . The status showed the Resident was severely and the physical limitations showed	A 162		

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A 162	Continued From page 25 diminished visual acuity, poor coordination and balance and the need for human assistance to ambulate. The activities of daily living (ADL) showed the Resident was independent for ambulation and transferring. Further review of Resident 2's record showed physician's orders for a wheelchair with seat belt dated . 5) Observation on at AM showed that Staff C attempted several times to assist Resident 5 to take his medication, but the Resident was unable to put the medication pill on his . Further observation showed that Staff C forcibly raised the Resident's with the medication cup to the Resident's , but the pill out of the Resident's . Interviewed on at 12:20 PM Staff C stated, "I can't give it [the medication] to him" Observation on at 12:23 PM revealed that Staff C discarded the medication pill and the Resident never took his medication dose. A review of Resident 5's health assessment dated showed diagnoses of . Dyskinesia, , . The physical limitations showed diminished visual acuity and poor coordination and balance. The status showed very . Needed assistance with self-administration of medication. According to JAMA (Journal of American Medical Association) Dyskinesia is a movement characterized by	A 162		

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A 162	Continued From page 26 severe, involuntary dystonic movements of the , oral and musculature. Class III	A 162		

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ZZ816 SS=D	408.809(2) 435.05(2) 59A-35.090(2d-3b) Background Screening-Compliance Attestation 408.809 Background screening; prohibited offenses.- (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's ␣ , to the Federal Bureau of Investigation for a national criminal history record check unless the person's ␣ , are enrolled in the Federal Bureau of Investigation's national retained print notification program. If the ␣ , of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit ␣ , electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the ␣ , to the Federal Bureau of Investigation for a national criminal history record check. The ␣ , shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person ␣ , . The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or	ZZ816		

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professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that:
(a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section;
(b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and
(c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency.

435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers:
(2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if for any of the disqualifying offenses while employed by the employer.

59A-35.090 Background Screening.
(d) Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, , herein incorporated by reference, must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if for any

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ZZ816	Continued From page 2 disqualifying offense. The Attestation of Compliance is available at https://www.flrules.org/Gateway/reference.asp?No=Ref-17724, and available from the Agency for Health Care Administration's website at: https://ahca.myflorida.com/health-care-policy-and-oversight/bureau-of-central-services/background-screening/additional-information/regulations. (e) An administrator or chief financial officer must be screened and qualified prior to , , to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, correspondence will be sent to the individual being screened requesting the report and court disposition information. Pursuant to Section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with Section 435.06(3), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation for attestation of compliance with background screening requirements for 1 out of 3 sampled staff (B) Findings included: A review of Staff B 's record showed no	ZZ816		

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ZZ816	Continued From page 3 documentation for an AHCA Recommended Form 3100-0008 Affidavit of Compliance with Background Screening Attestation. Further review revealed no documentation for a similar document attesting that Staff B was in compliance with the background screening requirements. Interviewed on at 1:55 PM the Administrator stated that she would obtain the attestation document for Staff B. Unclassified	ZZ816		