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
	AL11964835	A. BUILDING: _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFH SENIOR CARE CORAL SPRINGS	11937 NW 31ST STREET CORAL SPRINGS, FL 33065

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A unannounced Complaint survey (#2025016540) was conducted at AFH Senior Care Coral Springs on . Deficiencies were identified at the time of survey.	A 000		
A 031	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	A 031		

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A 031	Continued From page 1 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 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 maintain documentation of care coordination with third-party services for 3 of 3 residents reviewed (Residents #2, #3 and #4).	A 031		

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A 031	Continued From page 2 The findings included: At approximately 9:00 AM on , During an interview with Staff B requested records for all residents receiving third-party services. Staff B (Caregiver) identified this would be all residents currently in the facility (Residents 2, 3 and 4) as all are receiving hospice services. Review of the records furnished the following concerns were identified: Record review for Resident #4 revealed the following issues: a)No listed date of admission b) No documented coordination of care c) No written communication between facility and 3rd party service or documented attempt at communication (hospice) Record review for Resident #3 revealed the following issues: a)No listed date of admission b) documented coordination of care c)No written communication between facility and 3rd party service or documented attempt at communication (hospice) Record review for Resident #2 revealed the following issues: a)No listed date of admission b)No documented coordination of care c)No written communication between facility and 3rd party service or documented attempt at communication (hospice) At approximately 11:00am on , Surveyor Team met with Staff B for interview as she was verbally appointed by the Owner to conduct the	A 031		

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A 031	Continued From page 3 survey. Staff B was asked to provide documentation of Residents' admission dates, coordination of care and written communication between the facility and third-party service providers. She reported she did not have additional documentation to provide. Staff B was advised the lack of documentation would result in a deficiency for the facility. Class III	A 031		
A 077	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	A 077		

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A 077	Continued From page 4 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 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	A 077		

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A 077	Continued From page 5 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 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	A 077		

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A 077	Continued From page 6 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=Ref-09393. This Statute or Rule is not met as evidenced by: Based on observations, interview and record review, it was determined that, the facility failed to have an Administrator responsible for overseeing daily operations. The findings included: Upon arrival to conduct the licensure complaint at the facility on at approximately 8:30 AM, during an interview with Staff B (Caregiver), she stated that the Administrator and facility owner (Staff C) were not available. She was informed the Agency was onsite to conduct an unannounced survey and was asked to notify the Administrator (Staff A) of the surveyors' presence. Staff B stated she was not aware that the name provided by the surveyors was the facility Administrator (Staff A). Furthermore, she stated the facility Administrator was Staff D (Employee of parent organization). On at approximately 8:20 AM Staff B stated that Staff D was on the phone and would like to speak to the surveyors. When asked by the surveyor if she was the Administrator of the facility, she stated no. Review of the facility's employee records	A 077		

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A 077	Continued From page 7 revealed no documentation in file identifying that Staff D is the designated Administrator, Assistant Administrator or facility manager. During an interview on at approximately 11:00 AM Staff B confirmed she never met Staff A. Class III	A 077		
A 079	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 212 16-25 253 26-35 294 36-45 335 46-55 375 56-65 416 66-75 457 76-85 498 86-95 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for	A 079		

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A 079	Continued From page 8 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 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	A 079		

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A 079	Continued From page 9 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. (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	A 079		

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A 079	Continued From page 10 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 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 observations, interviews and record reviews, it was determined that, the facility failed	A 079		

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A 079	Continued From page 11 to provide adequate staffing to meet the care needs of the current residents (3 of 3.) This was evidenced by the facility's failure to ensure they had sufficient staff to provide supervision and care for the residents. This directly threatens the physical health, emotional well-being, and safety of all 3 residents receiving hospice care and has the potential to impact any resident admitted to care at the facility. Cross reference A0031, A0077, A0160, A0162. The findings included: Observations, interviews and record reviews completed on demonstrate noncompliance due to lack of supervision, documentation and provision of care and services. Upon entry to facility at approximately 8:30 AM, Staff B (Caregiver) was observed plating food for Resident 2 while Resident 3 was seated unattended (requires assistance with activities of daily living) on the couch in another room and Resident 4 was unattended (requires 2 person transfer) in her bedroom. At approximately 8:35 AM, Resident 3 was observed asking Staff B asking for his cellular device in order to contact his niece (Resident's representative.) Staff B was serving breakfast to Resident 2 and told Resident 3 he would need to wait until she was free to assist him. Further observation revealed Resident 3's pants and shirt were dirty. Resident 3 has identified ambulation issues, relies on a rolling walker and requires assistance with activities of daily living (ADLs.) During an interview at 8:49 AM, Resident 3 was asked if he	A 079		

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A 079	Continued From page 12 needed assistance with ␣. He confirmed but identified he needed to wait until Staff B had finished helping Resident 4 or until third party services (hospice) arrived to assist him. During an interview at 9:05 AM, with Staff B, she reported that she is the sole staff member at the facility and provided around the clock care. She reported to surveyor that if she needed a break, she contacted taff D (Employee of parent organization), to provide relief staffing. She reported she prioritizes care for Resident 4 due to the fact that she is a female. Reviewed posted staffing schedule which listed Staff B as only facility staff. Resident 2's sister arrived to transport him to a medical , , at approximately 9:25 am. She was observed providing a meal and produce to Staff B. During an interview with Resident 2's sister, she was asked why she was delivering groceries and prepared meals to the facility. She reported that she observed Staff B having difficulty managing her role responsibilities and identified her belief that Staff B was not provided with sufficient resources (specifically groceries) to complete her job functions. Resident 2's sister stated to the effect of, If I prepare a meal and bring it here, then that means she (Staff B) doesn't have to. At 10:20 AM, Resident 2's sister was observed returning with Resident 2. She was then observed seated at the dining table filling Resident 2's 2-week pill container. Upon questioning she reported that she does this every 2 weeks or when contacted by Staff B due to need. She identified that she holds her brother's medications at her home as she fills them for him. When	A 079		

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A 079	Continued From page 13 asked who would provide this service if she were unable to do so, she reported that there would not be a time she wouldn't be able to do it. She identified Staff B would be the person to step in if need be, but she takes this responsibility on in order to aid Staff B. On at 10:52 AM surveyor met with Staff B for interview regarding provision of care and services. Staff B was asked to provide Surveyor with a general outline of her daily schedule: 1. Self-care upon waking 2. Bathes Resident 4 (requires full ADL assistance) 3. Bathes Resident 2 (requires full ADL assistance) 4. Bathes Resident 2 (supervision/elopement risk) 5. 7:30 AM Begins breakfast preparation (concurrently providing care and services) 6. 8:00 AM Serves breakfast (concurrently providing care and services) 7. Medication pass 8. Cleans kitchen 9. 30 minute break for meal (attempted, but not consistently taken) 10. 11:00 AM Begins lunch preparation (concurrently providing care and services) 11. 12:00 PM Serves lunch (concurrently providing care and services) 12. Cleans kitchen 13. 4:00 PM Begins dinner preparation (concurrently providing care and services) 14. 5:00 PM Serves dinner (concurrently providing care and services) 15. Cleans kitchen 16. Mops the floor, does laundry and household cleaning Immediately prior to this interview with surveyors,	A 079		

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AFH SENIOR CARE CORAL SPRINGS	11937 NW 31ST STREET CORAL SPRINGS, FL 33065

(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 079	Continued From page 14 Staff B had begun lunch meal preparation. During the interview, Staff B had to leave interview twice in order to attend to a pot boiling over on the stove. When asked for Medication Observation Record (MOR,) Staff B reported that she had forgotten to complete it this date due to being caught up in other care and service duties to residents. Surveyor team noticed bottle of thickener used to accommodate special dietary needs on the counter in the kitchen and inquired after it. Staff B reported that she occasionally used it for Resident 2 when she remembered to put it in his water. Surveyors noted these examples as they evidenced the challenges Staff B and Resident 2's sister identified in Staff B being the sole staff member to provide care, services, supervision to all residents and facility maintenance In the same interview, Surveyor requested full record for all active residents as charts provided earlier were incomplete. Staff B reported that charts provided to surveyor team contained all available records. She had no additional documentation to provide. 1. Record review for Resident# 4 revealed the following issues: a. No listed date of admission b. No Health Assessment c. No written communication between facility and 3rd party service (hospice) Due to the lack of assessment (e,g, orders, diagnoses, description of ADL assistance required, etc) and lack of evidence of progress or decline (e.g., progress notes, coordination of care, etc.) in the Resident record, the Surveyor was unable to determine if Resident's care and service needs are currently being met at this facility or even if they can be accommodated at	A 079		

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A 079	Continued From page 15 the level of care able to be provided at a standard licensed Assisted Living Facility. It is unclear how the facility can make such a determination with the limited information available. 2. Record review for Resident #3 revealed the following issues: a. No listed date of admission b. No Health Assessment c. No written communication between facility and 3rd party service (hospice) Due to the lack of assessment (e.g, orders, diagnoses, description of ADL assistance required, special dietary needs, etc) and lack of evidence of progress or decline (e.g., progress notes, coordination of care, etc.) in the Resident record, Surveyor team is unable to determine if Resident's care and service needs are currently being met at this facility or even if they can be accommodated at the level of care able to be provided at a standard licensed Assisted Living Facility. It is unclear how the facility can make such a determination with the limited information available. 3. Record review for Resident #2 revealed the following issues: a. No listed date of admission b. No Health Assessment c. No written communication between facility and 3rd party service (hospice) Due to the lack of assessment (e.g, orders, diagnoses, description of ADL assistance required, elopement risk, etc) and lack of evidence of progress or decline (e.g., progress notes, coordination of care, etc.) in the Resident record, Surveyor team is unable to determine if Resident's care and service needs are currently being met at this facility or even if they can be accommodated at the level of care able to be	A 079		

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A 079	Continued From page 16 provided at a standard licensed Assisted Living Facility. It is unclear how the facility can make such a determination with the limited information available. In the same interview, Surveyor inquired who was responsible for updating records. Staff B reported that she was the only staff member assigned to the facility but that she had not been trained on charting. She identified if something significant happens, she writes the information down on a piece of paper but this does not enter the Resident's record. Staff B was asked to provide facility records to include admission & discharge log and grievance procedure but was unfamiliar with both and was unable to provide either. She was also asked to provide the Administrator's file for review but did not have such documentation. Further investigation revealed the facility is operating without an assigned administrator responsible for overseeing the facility, its staff and the appropriate provision of care and services to residents. In the same interview, Staff B identified her reliance on the assistance of hospice staff's scheduled visits to the facility to support and supplement her provision of care and services - , , in the case of Resident 4. She reported to surveyors that she is unable to transfer Resident 4 on her own due to concerns about her rigidity. Per Staff B's report, upon transfer Resident 4 straightens her fully and is unable to aid Staff B in moving her. Staff B reported she will not attempt moving Resident 4 on her own due to concern she will be unable to keep her safe. Staff B reported that hospice are in the facility to assist with residents Monday through Friday. She identified that she is unable to bathe all residents on Sundays due to lack of	A 079		

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A 079	Continued From page 17 support from hospice care. In the same interview, Staff B identified that Resident 2 goes into the backyard to smoke approximately every half hour. She further stated that Resident 2 has , is often and disoriented and is at risk for elopement. She reported she must supervise him in order to ensure he does not or enter the inground pool. She reported for these reasons, she does not allow him to smoke in the evenings as she cannot oversee the other residents, clean the facility and supervise him concurrently. On at approximately 11:00 AM, Surveyor team met with Staff B for exit interview as Administrator was not available and Owner requested exit be completed with onsite staff. It was identified that multiple deficiencies were present related to the demonstrated lack of supervision, missing documentation and level of care and services being provided to Residents #2, #3, and #4. Class III	A 079		
A 160	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	A 160		

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A 160	Continued From page 18 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 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.	A 160		

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A 160	Continued From page 19 (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 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 ;	A 160		

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A 160	Continued From page 20 (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, it was determined that, the facility failed to provide an up-to-date Admission / Discharge log, and Grievance procedures during survey. The findings included: During an interview on at approximately 10:50 AM, Staff B (Caregiver) was asked to provide the facility's up-to-date Admission / Discharge log, and Grievance procedures. Record review of the facility on revealed no documentation for an up-to-date Admission and Discharge log documenting as follows: 1) Date of Admission: facility or place from which resident is admitted 2) Date of Discharge: reason for discharge and identification of the facility or home address to which the resident was discharged. Grievance procedures 1) no written documentation on residents' complaints and suggestions (receiving and responding)	A 160		

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A 160	Continued From page 21 During an interview on at approximately 11:00 AM Surveyor team met with Staff B for an exit interview as Administrator was not available and facility owner requested exit be completed with onsite staff. Staff B was informed of the missing items mentioned above. No additional documentation was provided during the survey. Class	A 160		
A 162	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 implemented by the facility that require a health	A 162		

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A 162	Continued From page 22 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 written statement of funds or other property	A 162		

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A 162	Continued From page 23 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 provided with a copy of their records upon	A 162		

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A 162	Continued From page 24 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 interview and record review, the facility failed to maintain resident records as required for 3 of 3 residents reviewed (Residents #2, #3 and #4.) The findings included: At approximately 9:00 AM on , Surveyor Team requested records for all residents. Staff B (Caregiver) provided what she identified as the full resident record for Resident #2, #3, and #4. At approximately 10:00 AM on , Surveyor Team completed record reviews for the facility. Records furnished for review were deficient as outlined below: Record review for Resident 4 revealed the following issues: No listed date of admission No Resident Health Assessment No record No physician's orders No informed consent for self-administration for medication by unlicensed staff No copy of Resident's contract No written documentation of hospice status or interdisciplinary care plan Record review for Resident 3 revealed the following issues: No listed date of admission	A 162		

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A 162	Continued From page 25 No Resident Health Assessment No ␣ record No physician's orders No informed consent for self-administration for medication by unlicensed staff No copy of Resident's contract No written documentation of hospice status or interdisciplinary care plan Record review for Resident 2 revealed the following issues: No listed date of admission No Resident Health Assessment No ␣ record No physician's orders No informed consent for self-administration for medication by unlicensed staff No copy of Resident's contract No written documentation of hospice status or interdisciplinary care plan At approximately 11:00 AM on , Surveyor Team met with Staff B for interview as she was verbally appointed by the Owner to conduct the survey. Staff B was asked to provide missing documentation outlined above. Staff B reported she did not have additional documentation to provide. Staff B was advised the lack of documentation would result in a deficiency for the facility. Class III	A 162		

Agency for Health Care Administration

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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		

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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
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 observation, record review and interview, it was determined that the facility failed to maintain changes in employment status of employees within the Agency for Health Care Administration (AHCA) Background Screening Clearinghouse within five business days for 1 of 1 sampled staff (Staff A). The findings included: Team of surveyors arrived at the facility on at approximately 8:30 AM, Surveyors were greeted by Staff B (Caregiver) who stated that the Administrator (Staff A) was not available. Staff B was informed the Agency was onsite to conduct an unannounced survey and was asked to notify the Administrator (Staff A) of the surveyors' presence. Review of the Agency's website www.healthfinder.fl.gov under facility locator	ZZ814		

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	AL11964835	A. BUILDING: _____ B. WING _____	03/03/2026

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ZZ814	Continued From page 2 revealed the provider's name (facility name) and the Administrator name as Staff A. During a conference call on at approximately 8:20 AM with Staff C (facility owner), he provided a phone number for Staff A for surveyors to call and let her know of the nature of the Agency's visit. During an interview on at approximately 8:25 AM Staff B was informed to provide the employee file for the Administrator. At this time, she stated the facility does not have an employee file for the Administrator (unknown hire date). On at approximately 12:45 PM, Staff A forwarded the resignation letter email to the surveyor, which was originally sent to the facility's owner on . Review of the Administrator's resignation letter addressed to Staff C (via email) revealed a letter that was signed and dated . Unclassified	ZZ814		
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	ZZ815		

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ZZ815	Continued From page 3	ZZ815		

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 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

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ZZ815	Continued From page 4 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 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.	ZZ815		

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ZZ815	Continued From page 5 (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 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	ZZ815		

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ZZ815	Continued From page 6 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 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	ZZ815		

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ZZ815	Continued From page 7 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 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	ZZ815		

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ZZ815	Continued From page 8 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, 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	ZZ815		

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ZZ815	Continued From page 9 contractors, licensees, or volunteers. This Statute or Rule is not met as evidenced by: Based on interviews, record review and observation, the facility failed to obtain Level II background screening for the facility Administrator (Staff D) who oversees the daily operations of the facility and who assists in providing care and services to the residents. 1 of 2 sample employees (Staff D). The findings included: Team of surveyors arrived at the facility on at approximately 8:30 AM, Surveyors were greeted by Staff B (Caregiver) who stated that the Administrator and Facility Owner (Staff C) were not available. At this time, Staff B was asked to notify the Administrator (Staff A) that the Agency's surveyors were onsite. Staff B stated she was not aware that the name provided by the surveyors was the facility Administrator (Staff A). Furthermore, she stated the facility Administrator was Staff D (Employee of parent organization). Staff B was asked to provide an employee file for Staff D. She stated the facility did not have an employee record for Staff D at that time. Subsequently, she was requested to provide full name for Staff D. A request was made to Staff B to provide the facility's updated roster and staffing schedule. Review of the facility's staffing schedule revealed one staff member (Staff B); no employee roster was provided for review. During confidential interviews with family members on between 9:00 AM and	ZZ815		

Agency for Health Care Administration

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ZZ815	Continued From page 10 11:00 AM it was revealed that Staff D contacts the resident's family members and she is identified as the facility Administrator. Furthermore, Staff D communicates with family members regarding updates (e.g., care and services, medical, issues concerns). On at approximately 8:20 AM Staff B stated that Staff D was on the phone and would like to speak to the surveyors. When asked if she was the Administrator of the facility, she stated no. Unclassified	ZZ815		