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
	AL11969790	A. BUILDING: _____ B. WING _____	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HARRISON ASSISTED LIVING AND MEMORY CA	650 NW FORK RD STUART, FL 34994

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced Complaint survey (#2025012520, #2025013531, #2025017066, #2026000830 & #2026001945), and a Generator Monitoring survey were conducted on and 13th, 2026 at The Harrison Assisted Living And Memory Care Of Stuart. The facility had deficiencies related to the complaint (#2025012520, #2026000830 & #2026001945) identified at the time of the visit.	A 000		
A 011	59A-36.006(5) FAC Admissions - Discharge (5) DISCHARGE. If the resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident's needs, as determined by the facility administrator or health care practitioner, the resident must be discharged in accordance with Section 429.28, F.S. This Statute or Rule is not met as evidenced by: Based on record review and an interview, it was revealed that the facility failed to provide a written notice of relocation or termination of residency 45 days prior to the transfer of 1 of 2 sampled residents (Resident #1) whose move was initiated by the facility. The findings included: Resident #1 moved into the facility on . The resident's health assessment (AHCA Form 1823) dated noted the resident's diagnoses including with aggression (special precaution) wheelchair dependent. It is noted that the resident has , and requires redirection with behavioral episodes. The resident is an elopement risk. It is documented that the resident requires "total care" with bathing and , and "assistance" with	A 011		

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A 011	Continued From page 1 ambulation, transferring, toileting, eating and self-care. The assessment documents that the resident is not appropriate for Assisted Living Facility (ALF) residency. The resident's Progress Notes include documentation on of past behavior occurrences since , including a note dated at 3:50 PM that a "phone call placed to (resident's representative) from (Resident Services Director) and (name of unknown 3rd party provider) regarding a 45 day notice. On , it is noted that the resident's representative had a meeting with the Executive Director, , Memory Care Director and Practitioner "to discuss alternative placement d/t (due to) mental health behaviors. Family representative understands and agrees that behaviors are not able to be managed here". During interview with the Administrator on at 2:45 PM, it was confirmed that a 45 day notice was not provided to this resident's representative with the ombudsman's contact information and reason for initiating a transfer. Class III	A 011		
A 025	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	A 025		

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A 025	Continued From page 2 acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making . . . for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of 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.	A 025		

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A 025	Continued From page 3 (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to provide timely care and investigate thoroughly an injury of unknown origin for 1 of 5 sampled residents (Resident #5) who sustained a ; and, failed to ensure 4 of 4 sampled residents (Residents #6, #7, #8 and #9) were provided personal supervision as appropriate for activities of daily living (ADLs); and, failed to provide supervision to prevent 1 of 1 sampled residents (Resident #3) from exiting the secured unit. The findings included: 1. Resident #5 was assessed on a health assessment (AHCA Form 1823) dated with diagnoses including with a history of . The resident was noted to have related agitation and required assistance with ambulation, transferring, self-care and toileting. An adverse report filed by the facility on documents that the resident was "noted with , during morning care prior to breakfast". It states "it is unknown if the resident had a ". The hospice nurse is documented as sending the resident to the hospital at 3:30 AM on after notifying the Med Tech on duty that the resident sustained a to his (,). It is documented that an internal investigation	A 025		

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A 025	Continued From page 4	A 025		

confirms no at community since on . There were no details of the investigation on the report. The facility indicates on the report that a corrective or proactive action taken by the facility is that regardless of whether or not a resident is on hospice, if the resident has and of an extremity, they should be sent to the hospital for evaluation.

The facility's Progress Notes for this resident show the following:

a. "c/o (complained of) L (left) ...nurse contacted on-call (name) APRN (Advanced Practice Registered Nurse who stated a stat (immediate) will be ordered"
b. "Med Tech reports the resident having had a at another time. The resident complained of to the left ... showed the resident to have displaced to the lower left ...911 called"
c. "LATE ENTRY resident c/o ...RN (Registered Nurse) (Hospice) stated they will follow up"
d. "LATE ENTRY "left appeared , this writer notified (name) RN (Hospice) to follow up from previous day"

A copy of a text sent from Staff E (LPN/Licensed Practical Nurse) to the resident's APRN at 9:28 AM on showed the facility initially notified the health care practitioner of the resident's complaints of "severe in the left ...we are unable to move his without him yelling out in ". The response was that a "stat" would be ordered for the resident's left . There was no documentation of follow up in the notes to show the was completed over the weekend from through . However, after inquiry, an email sent to

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A 025	Continued From page 5 the Administrator dated at 4:01 PM shows the APRN stated "I believe because of Hospice, I wanted to wait for (name of Hospice nurse) to assess on Monday ( )". The resident's file contained a "stat" order dated . The adverse report notes that an (mobile) was attempted on but that the resident was combative so it was not successful. There was no documentation from the mobile company or in the resident's Progress Notes showing an attempt was made. An exam result dated documents that the resident sustained an acute of the left . It could not be determined why the APRN waited for two days while the resident was in to order the "stat" that was planned, or if the Hospice nurse was notified over the weekend before . It could not be determined why the mobile company did not arrive to the facility to attempt an until two days after the "stat" order was written. Additionally, it was not clear why the facility did not send the resident to the hospital initially when the resident was in severe with an inability to move his on , until the ordered mobile was completed six days later. 2. The secured unit, where residents of the facility with resided, was toured on at 11:00 AM. The unit is shaped like a "U" with two common areas on each side, one where activities were taking place and another side with a dining area. There was an outdoor courtyard with doors that remained locked separating the two common areas. Resident #8 was observed seated in her wheelchair attempting to propel it forward while it was caught on another chair with no staff present in the	A 025		

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A 025	Continued From page 6 common area next to the activity that was taking place. Resident #9 was observed at the corner of the activity area side seated in a wheelchair facing a wall, out of the line of sight of staff. Resident #6 was seated in a wheelchair at a table on the other side of the unit in the dining room with his wheelchair wheels locked as the resident appeared to be sleeping. Resident #7 and another random resident was observed seated at dining room tables by themselves. From 11:00 AM to 12:00 PM, the residents in the dining room were observed unsupervised with no staff interaction or activity suggested. Review of the health assessments (AHCA Form 1823) for four residents were reviewed and noted the following. a. Resident #6-Assessment completed on . Diagnoses include , legally , , history of , , . status is noted as memory , . Special precaution is noted as " ". The resident requires "assistance" with ambulation, transferring, toileting and self-care. b. Resident #7-Assessment completed on . Diagnosis is . status is noted as alert with . Special precaution is noted as " ". The resident is noted as at risk for elopement (escaping the secured area). c. Resident #8-Assessment completed on . Diagnoses include mild , , , , . status is noted as alert and oriented x2 (person/place/time). The resident requires "assistance" with toileting and "supervision" with ambulation, transferring, and self-care. d. Resident #9-Assessment completed on . Diagnoses include , , and , . Physical limitation include an unsteady gait and frequent .	A 025		

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A 025	Continued From page 7 ᵕ status is noted as and memory ' . Special precaution is noted as " ". The resident requires "assistance" with toileting, ambulation, transferring, and self-care. Review of the staffing schedule and resident census for the secured unit revealed there are 4 caregivers assigned to 34 current residents, most of which are and require observation for safety. There were no staff observed during the aforementioned time in the dining room area on the opposite side of the unit from where the activity was being held. It is unknown how each caregiver, with approximately 8 residents each to care for, was able to provide a shower or toileting assistance without leaving the other 7 residents on their assignment unattended. There were no requirements for at least one staff member to remain in the 2 common areas to provide supervision or assistance to residents as needed. During interview with Resident #3's representative on at 2:00 PM, it was revealed that the resident had escaped the secured unit on . The representative voiced concern about the supervision of residents in the secured unit, and medication being initiated or used for resident behaviors that are a symptom of ᵕ diagnoses including , instead of direct care staff providing supervision as needed. 3. Review of Resident #3's health assessment (AHCA Form 1823) dated notes diagnoses including and , ( ). The ᵕ status is documented as alert and oriented x1 (person/place/time) and able to make some needs known. There was no special precaution or elopement risk indicated. The resident was to receive assistance with	A 025		

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A 025	Continued From page 8 transferring, toileting and self-care. During observation of the resident on and between 11:00 AM and 2:00 PM, she was observed walking throughout the secured unit as well as out of the secured unit with her representative at various times using no assistive device and without difficulty. The resident was pleasant, able to have a conversation and voice her basic needs during interview on at 2:00 PM. Review of the resident's Progress Notes revealed the concierge alerted the nurse on duty on at 3:00 PM that the resident was "in process of exiting neighborhood (secured unit) from dining room door" and that a caregiver and the Executive Director , (EDS) escorted the resident to the neighborhood. Observation of the video footage with the Administrator on and showed the EDS opened the door to the secured unit to allow access for 2 movers to enter, then approximately 20 seconds after the door closed, Resident #3 was observed opening the door that was supposed to lock automatically when closed. The resident slowly walked around the hallway towards an exit double door that was propped open by another mover and appeared to exchange words with him before he let the resident walk past him outside. A few seconds later, the EDS entered into the hallway area and then outside, and returned with the resident and a caregiver. Review of the Progress Notes revealed no determination as to how the door that was supposed to automatically lock was opened by the resident on . During interview with the Administrator on at 2:30 PM, she stated that the door must have been left open for an extended period of time which caused it to not	A 025		

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A 025	Continued From page 9 lock at the time of the incident. On at 2:40 PM, the door was held open by the Administrator for an extended amount of time, but the door still locked automatically. The door not locking automatically could not be replicated with this writer and the Administrator's attempts on . . . During interview with the Administrator on at 12:03 PM, she stated that the concierge had the secured door temporarily while the movers were being escorted with the EDS present at the time of the incident, and that the concierge had since been counseled for this. The facility did not have procedures in place to ensure residents did not exit the secured unit, and were not conducting thorough investigations into incidents to identify lack of supervision by staff to prevent reoccurrence. These findings were reviewed with the Administrator during interviews on at 3:00 PM and again telephonically on . . . . . at 12:03 PM. The facility provided no additional information for review at this time. Class III	A 025		
A 030	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the	A 030		

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A 030	Continued From page 10	A 030		

admission package provided pursuant to Rule 59A-36.006, F.A.C.
(b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint.
(c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and , ;
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and standard precautions;

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A 030	Continued From page 11 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and	A 030		

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A 030	Continued From page 12 personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , ,	A 030		

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A 030	Continued From page 13 for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.	A 030		

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A 030	Continued From page 14 (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated . or . under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the	A 030		

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A 030	Continued From page 15 facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on interviews and record review, it was determined that the facility failed to have an effective Grievance procedure for receiving and responding to resident complaints, and to allow residents to recommend changes to facility policies and procedures and services for 3 of 3 sampled residents (Residents #3, #4 and #7). The findings included: During review of the facility's Grievance policy and procedure on , the following steps were noted: a. The resident and/or responsible party should discuss the complaint with the associate and Executive Director. b. If unable to resolve grievance with step 1, the grievance should be submitted in writing to the Executive Director utilizing the Grievance/Concern Report. The Executive Director should provide a response to the resident and/or resident's responsible party within fourteen (14) days of receipt of the complaint. c. If unable to resolve grievance with step 2, the written grievance should be submitted to the Regional Director of Operations. The Regional	A 030		

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A 030	Continued From page 16 Director of Operations should provide a response to the resident and/or resident's responsible party within fourteen (14) days of receipt of the complaint. The policy and procedure does not require the facility to respond to a grievance within a measurable timeframe or in writing if the grievance is not documented on the Grievance/Concern Report form. Therefore, the following identified grievances were not addressed in a timely manner and did not include changes in the facility's policies and procedures to prevent reoccurence. The limited documentation of the appropriate resolutions were not in a centralized location which prevented the facility staff from being held accountable for their individual responses, with limited oversight from department heads and corporate representatives. 1. Resident #3's representative stated during interview on at 2:00 PM that the facility has been notified of her concerns about the resident's safety in the secured unit due to the resident's ability to exit without supervision and no notification of the incident, the facility's communication to the hospice nurse that , , , medication was an option after the representative removed these medications from the resident's prescriptions and concerns about supplies delivered by hospice being left in bags in the resident't closet without staff putting them in the designated supply area. A. Review of the video of the resident's exit from the secured unit on revealed the resident was able to open a door that was supposed to automatically lock when closed. She was unsupervised for a brief period of time while	A 030		

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A 030	Continued From page 17 entering a hallway outside the secured unit, and then outside the building, before being seen by a caregiver and the Executive Director , (EDS) who returned her to the secured unit. It was later determined, after discussion with the Administrator on at 3:00 PM, that the door lock was by the concierge without added staff to supervise the exit door while movers were entering and exiting the unit. The Administrator (Executive Director) emailed a response on at 2:12 PM to the representative's emailed concerns sent to the Administrator and Executive Director , (EDS) on at 12:02 AM that included the following. a. "...our team maintained visual contact with her at all times and monitored her continuously. At no point was she outside the supervision of staff." It was later determined that the "exit seeking" that the concierge left a door unlocked that should not have been. b. "I do agree, however, that you should have been notified the same day...We have already reinforced expectations with out team regarding timely communication with responsible parties moving forward". There is no documentation of a staff member who was retrained or counseled to ensure they did not repeat the mistake of not notifying a representative of an incident such as this one. c. " I also want to acknowledge that this type of exit seeking behavior is new for (the resident)...your decision to discontinue all medications-including those that support behavioral stability-has coincided with noticeable changes in her patterns". The resident's exit from the secured unit was not due to her behavior, but rather due to the facility staff's mistake of	A 030		

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A 030	Continued From page 18	A 030		

disabling the secured unit door. Medication changes suggested by the facility for a behavior that did occur or cause harm to the resident or others should be discussed with the resident's representative first to ensure their right to refuse or obtain their choice of a third party medical provider for an assessment is honored.

B. On at 11:45 AM, the representative stated during interview that the resident's supplies from hospice had been delivered again in a bag left in the resident's closet on . She stated that the LPN (Licensed Practical Nurse) had assured her that this would not happen again. At 12:00 PM, the LPN stated during interview that he was the staff member that placed the bag in the resident's closet on the floor on because it was "during lunch time". Review of the Progress Notes for this resident revealed the LPN documented on that "staff responsible would be educated...every /MT (Resident Aide and Med Tech) on each shift...we monitor these closets by keeping up to par...writer is monitoring this situation daily...These communications have been relayed to writer's immediate supervisor as well as our Executive Director". There was no grievance logged when grievances were requested for this facility, no documentation to show who was educated about the supply storage, and no follow up noted to ensure it did not continue happening. Additionally, the LPN who noted he was responsible for resolving this grievance did not follow the steps he put in place to prevent reoccurrence.

The responses to the grievances were not resolved as of the survey date on , and did not include measurable outcomes and who was accountable to ensure the facility was

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A 030	Continued From page 19 providing services to prevent reoccurence. 2. Resident #4's representative sent an email to the facility's Administrator with a list of grievances on at 9:40 PM, including the following: a. care not provided for 6 to 11 hours. Requested scheduled care to be provided. b. Charged for 2 person assist provided to resident with showers, but resident no longer takes showers and hospice staff provide the 1 person assist bed bath that is received three times a week, with no adjustment to contractual fees. c. and cream have not been provided as ordered. d. Linens not changed on the bed for weeks. Housekeeping charged $100 for deep cleaning but only cleaned for 10 minutes in resident's room. e. Laundry not done weekly for multiple weeks. f. High fat, and meals provided. g. Activities were limited, mostly consisting of coloring and television. On at 3:38 PM, a follow up request email was sent to another corporate representative. On at 6:45 PM, the Regional Vice President responded in an email to the grievances as follows, in a summarized version: a. Brief checks (care) was assigned frequently throughout each shift. b. Are there specific dates and medications that were missed? c. Housekeeping and laundry concerns were addressed at the time you brought this to the	A 030		

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A 030	Continued From page 20 facility's attention as indicated on grievances. d. Activities were still taking place...planned calendars were followed. The responses did not show a thorough investigation into the concerns, or a plan to prevent reoccurence, or reference to the regulatory guidelines being followed. It is unclear by the responses that the facility maintained a procedure for grievances to be addressed and resolved. 3. Resident #7's representative stated during interview on at 12:15 PM that the facility had been notified of multiple grievances over a two year period, but that they had not been resolved. The representative stated that they have provided housekeeping and personal care for this resident themselves since the facility staff do not. The previous secured unit director was notified of the ongoing complaints, but the representative had not filled out a grievance form for them, so it is unkown what was brought to the facility's attention and how any concerns were resolved from previous staff. Documentation of grievances was requested from the Administrator on at 11:00 AM. The facility provided no grievances documented or logged at the time of the survey. Grievances were communicated to various staff members, department heads, corporate representatives and the ombudsman with no way to keep track of what was addressed, if it was resolved, and how the facility prevented reoccurence since there was no record maintained in a centralized form. Furthermore, there was no family council held for secured unit residents with , who were unable to attend the Resident Council held monthly for other Assisted Living Facility	A 030		

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A 030	Continued From page 21 residents to voice concerns. The Administrator, Regional Vice President and were notified of these findings on at 3:00 PM. The facility provided no additional information for review at this time. Class III	A 030		
A 170	429.24(3)a Resident Refund Policy ....The facility shall provide a refund to the resident or responsible party within 45 days after the transfer, discharge, or of the resident. The agency shall impose a fine upon a facility that fails to comply with the refund provisions of the paragraph, which fine shall be equal to three times the amount due to the resident. One-half of the fine shall be remitted to the resident or his or her estate, and the other half to the Health Care Trust Fund to be used for the purpose specified in s. 429.18. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to provide a prorated refund based on the daily rate within 45 days of a resident's transfer for 1 out of 3 sampled residents (Resident #4). The findings included: On at 10:56 AM, an email was sent by Resident #4's representative to the facility's Administrator notifying her that the resident would be moving out within 30 days. On , Resident #4 moved out of the facility. During interview with the resident's representative on at 9:08 AM, she stated that she moved	A 170		

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A 170	Continued From page 22 the resident's belongings out of her apartment on the same day. A refund was provided by a check dated in the amount of $3,164.24, more than 45 days after the resident's transfer. The facility's Ledger erroneously noted that the refund was disbursed on . Chapter 429.24 (3), Florida Statute, requires that a refund policy "shall provide a refund to the resident or responsible party within 45 days after the transfer, discharge, or of the resident". The Administrator was notified of these findings on at 3:00 PM. The facility provided no additional information for review at the time of the survey. Class III	A 170		

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ZZ830	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider	ZZ830		

AHCA Form 3020-0001

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

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ZZ830	Continued From page 1 is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database	ZZ830		

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ZZ830	Continued From page 2 approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on record review and an interview, the facility failed to submit their Comprehensive Emergency Management Plan (CEMP) revisions by the required deadline to the county for review and approval. The findings included: On at 4:24 PM, an email was sent to the facility by a county representative with the Emergency Management Division stating that the facility's CEMP required revisions. The county representative stated in an email dated at 9:59 AM that the facility had not had an approved plan since their last approval on , prior to their name change. These findings were discussed with the Administrator on at 2:00 PM. The facility provided no additiona information for review at the time of the survey. On at 11:00 AM, an email from the county representative noted that the facility Administrator had met with her on but that no revisions had been received from the facility. The facility has thirty (30) days to respond to requested revisions of their CEMP for the annual approval by the county.	ZZ830		