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
	AL11969925	A. BUILDING: _____ B. WING _____	04/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA ALF LLC	14335 SW 288TH ST HOMESTEAD, FL 33033

(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
ZZ809	59A-35.062(3)(e)&(7);408.803(7) &.810(8) Proof of Financial Ability to Operate 59A-35.062 Proof of Financial Ability to Operate. (3) Definitions. The following definitions apply to this section for proof of financial ability to operate. (e) "Financial instability" means the provider cannot meet its financial . Evidence such as the issuance of bad checks, an accumulation of delinquent bills, or inability to meet current payroll needs shall constitute prima facie evidence that the ownership of the provider lacks the financial ability to operate. Evidence shall also include the Medicare or Medicaid program's indications or determination of financial instability or fraudulent handling of government funds by the provider. 408.803 Definitions.-As used in this part, the term: (7) "Controlling interest" means: (a) The applicant or licensee; (b) A person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the applicant or licensee; or (c) A person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider. The term does not include a voluntary board member. 408.810 Minimum licensure requirements.-In addition to the licensure requirements specified in this part, authorizing statutes, and applicable rules, each applicant and licensee must comply with the requirements of this section in order to obtain and maintain a license.	ZZ809		

AHCA Form 3020-0001

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

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ZZ809	Continued From page 1 (8) Upon application for initial licensure or change of ownership licensure, the applicant shall furnish satisfactory proof of the applicant's financial ability to operate in accordance with the requirements of this part, authorizing statutes, and applicable rules. The agency shall establish standards for this purpose, including information concerning the applicant's controlling interests. The agency shall also establish documentation requirements, to be completed by each applicant, that show , provider revenues and expenditures, the basis for financing the , cash-flow requirements of the provider, and an applicant's access to contingency financing. A current certificate of authority, pursuant to chapter 651, may be provided as proof of financial ability to operate. The agency may require a licensee to provide proof of financial ability to operate at any time if there is evidence of financial instability, including, but not limited to, unpaid expenses necessary for the basic operations of the provider. An applicant applying for change of ownership licensure is exempt from furnishing proof of financial ability to operate if the provider has been licensed for at least 5 years, and: (a) The ownership change is a result of a corporate reorganization under which the controlling interest is unchanged and the applicant submits organizational charts that represent the current and proposed structure of the reorganized corporation; or (b) The ownership change is due solely to the of a person holding a controlling interest, and the surviving controlling interests continue to hold at least 51 percent of ownership after the change of ownership. 59A-35.062 Proof of Financial Ability to Operate.	ZZ809		

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ZZ809	Continued From page 2 (7) An applicant for renewal of a license shall not be required to provide proof of financial ability to operate, unless the licensee or applicant has demonstrated financial instability. If an applicant or licensee has shown signs of financial instability, as provided in Section 408.810(9), F.S., at any time, the Agency may require the applicant or licensee to provide proof of financial ability to operate by submission of: (a) AHCA Form 3100-0009, , Proof of Financial Ability Form, that includes a balance sheet and income and expense statement for the next 2 years of operation which provide evidence of having sufficient assets, credit, and projected revenues to cover liabilities and expenses; and, (b) Documentation of correction of the financial instability, including but not limited to, evidence of the payment of any bad checks, delinquent bills or liens. If complete payment cannot be made, evidence must be submitted of partial payment along with a plan for payment of any liens or delinquent bills. If the lien is with a government agency or repayment is ordered by a federal or state court, an accepted plan of repayment must be provided. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide documentation of financial stability for the past three months to meet its financial stability as evidence of insufficient food. Findings: Observation on at 7:09 AM found a refrigerator accessible to the residents with only a bag of lettuce and no milk, fruits, juices or available snacks displayed on top of the counter	ZZ809		

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ZZ809	Continued From page 3 or in the cabinets. Photographic evidence obtained. Observation on at 07:10 AM found a 2nd refrigerator locked in an office and not accessible to the residents contained: ½ gallon milk, 1 jar mayonnaise ,1 six pack of non- Malta, 1 can tomato paste, 3 1-liter bottles of soda, and 2 boxes of sugar cane cubes. However, Staff B (Caregiver) stated that some of the items belonged to him. Interviewed on at 2:26 PM when asked to provide bank statements for the past three months (, and , the Administrator stated that she would. Interviewed on at 1:37 PM the Administrator stated that she sent the statements to the office. Unclassified	ZZ809		
ZZ875	430.5025(4 &) / ; Training (4) Employees of covered providers must complete the following training for 's and related forms of : (a) Upon beginning employment, each employee must receive basic written information about interacting with persons who have 's or related forms of . (b) Within 30 days after beginning employment, each employee who provides personal care to or has regular contact with participants, patients, or residents must complete a 1-hour training program provided by the department. 1. The department shall provide training that is	ZZ875		

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ZZ875	Continued From page 4 available online at no cost. The 1-hour training program shall contain information on understanding the basics about the most common forms of , how to identify the signs and symptoms of , and skills for communicating and interacting with persons with 's or related forms of . A record of the completion of the training program must be made available to the covered provider which identifies the training curricula, the name of the employee, and the date of completion. 2. A covered provider must maintain a record of the employee's completion of the training program and, upon written request of the employee, provide the employee with a copy of the record of completion consistent with the employer's written policies. 3. An employee who has completed the training required in this subsection is not required to repeat the program upon changing employment to a different covered provider. (c) Within 7 months after beginning employment for a home health agency, nurse registry, or companion or homemaker service provider, each employee who provides personal care must complete 2 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person 's independence in activities of daily living, and skills in working with families and caregivers. (d) Within 7 months after beginning employment for a nursing home, an assisted living facility, an adult family-care home, or an adult day care center, each employee who provides personal care must complete 3 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not	ZZ875		

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ZZ875	Continued From page 5 limited to, behavior management, promoting the person's independence in activities of daily living, skills in working with families and caregivers, group and individual activities, maintaining an appropriate environment, and ethical issues. (e) For an assisted living facility, adult family-care home, or adult day care center that advertises and provides, or is designated to provide, specialized care for persons with 's or related forms of , in addition to the training specified in paragraphs (a) and (b), employees must receive the following training: 1. Within 3 months after beginning employment, each employee who provides personal care to or has regular contact with the residents or participants must complete the additional 3 hours of training as provided in paragraph (d). 2. Within 6 months after beginning employment, each employee who provides personal care must complete an additional 4 hours of -specific training. Such training must include, but is not limited to, understanding and related forms of , the stages of 's , communication strategies, medical information, and stress management. 3. Thereafter, each employee who provides personal care must participate in at least 4 hours of continuing education each calendar year through contact hours, on-the-job training, or electronic learning . For this subparagraph, the term "on-the-job training" means a form of direct coaching in which a facility administrator or his or her designee instructs an employee who provides personal care with guidance, support, or -on experience to help develop and refine the employee's skills for caring for a person with 's or a related form of . The continuing	ZZ875		

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ZZ875	Continued From page 6 education must cover at least one of the topics included in the -specific training in which the employee has not received previous training in the previous calendar year. The continuing education may be fulfilled and documented in a minimum of one quarter-hour increments through on-the-job training of the employee by a facility administrator or his or her designee or by an electronic learning , chosen by the facility administrator. On-the-job training may not account for more than 2 hours of continuing education each calendar year. (f)1. An employee provided, assigned, or referred by a health care services pool must complete the training required in paragraph (c), paragraph (d), or paragraph (e) that is applicable to the covered provider and the position in which the employee will be working. The documentation verifying the completed training and continuing education of the employee, if applicable, must be provided to the covered provider upon request. 2. A health care services pool must verify and maintain documentation as required under s. 400.980(5) before providing, assigning, or referring an employee to a covered provider. (7) For a certified nursing assistant as defined in s. 464.201, training hours completed as required under this section may count toward the total hours of training required to maintain certification as a nursing assistant. (8) For a health care practitioner as defined in s. 456.001, training hours completed as required under this section may count toward the total hours of continuing education required by that practitioner's licensing board. (9) Each person employed, , or referred to provide services before , , , , must complete the training required in this section before , , . Proof of completion of	ZZ875		

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ZZ875	Continued From page 7 equivalent training completed before , , , shall substitute for the training required in subsection (4). Each person employed, , or referred to provide services on or after , , may complete training using approved curriculum under paragraph (5)(d) until the effective date of the rules adopted by the department under subsection (6). This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure two (Administrator & Staff B Caregiver) out of two sampled employees obtain one-hour training provided by the Department of Elder Affairs on understanding the basics and most common forms of , and skills for communicating and interacting with persons with 's . Findings: Observation on at 6:40 AM found Staff B alone with five residents. Observation on at 7:50 AM the Administrator arrived in the facility. A review of the Administrator's personnel records showed a hire date of and no one-hour training regarding 's and Related provided by the Department of Elder Affairs. A review of Staff B's personnel records showed a hire date and no one-hour training provided by the Department of Elder Affairs. Interviewed on at 12:15 PM the	ZZ875		

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ZZ875	Continued From page 8 Administrator stated, "Is it so?" Unclassified	ZZ875		

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A 180 SS=D	59A-36.019(1) FAC Emergency Management (1) EMERGENCY PLAN COMPONENTS. Pursuant to Section 429.41, F.S., each facility must prepare a written comprehensive emergency management plan using "Minimum Emergency Management Planning Criteria for Assisted Living Facilities," AHCA Form 3180-5006, . , incorporated by reference and available at http://www.flrules.org/Gateway/reference.asp?No=Ref-15964. The form is also available at: https://ahca.myflorida.com/MCHQ/Emergency_Activities/index.shtml. The emergency management plan must, at a minimum, address the following: (a) Provision for all hazards; (b) Provision for the care of residents remaining in the facility during an emergency, including pre-disaster or emergency preparation; protecting the facility; supplies; emergency power; food and water; staffing; and emergency equipment; (c) Provision for the care of residents who must be evacuated from the facility during an emergency including identification of such residents and transfer of resident records; evacuation transportation; sheltering arrangements; supplies; staffing; emergency equipment; and medications; (d) Provision for the care of additional residents who may be evacuated to the facility during an emergency including the identification of such residents, staffing, and supplies; (e) Identification of residents with 's or related , and residents with mobility limitations who may need specialized assistance either at the facility or in case of evacuation; (f) Identification of and coordination with the county emergency management agency; (g) Arrangement for post-disaster activities	A 180		

AHCA Form 3020-0001

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A 180	Continued From page 1 including responding to family inquiries, obtaining medical intervention for residents, transportation, and reporting to the county emergency management agency the number of residents who have been relocated, and the place of relocation; and, (h) The identification of staff responsible for implementing each part of the plan. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide documentation of a Comprehensive Emergency Management Plan (CEMP), including a mutual aid agreement in the event of an evacuation. Findings: Observation on at 6:40 AM found five residents and one staff in the facility. A review of the facility records found an approved comprehensive emergency power plan (CEMP) dated . However, there were no plans on file including evacuation plans, and the mutual aid agreement involving the transfer and receiving facility. Interviewed on at 12:15 PM the Administrator acknowledged a plan was not onsite and stated further, "Okay." Class III	A 180		
A 200 SS=E	59A-36.025 FAC Emergency Environmental Control	A 200		

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A 200	Continued From page 2 59A-36.025 Emergency Environmental Control for Assisted Living Facilities. (1) DETAILED EMERGENCY ENVIRONMENTAL CONTROL PLAN. Each assisted living facility shall prepare a detailed plan ("plan") to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency environmental control in the event of the loss of primary electrical power in that assisted living facility which includes the following information: (a) The acquisition of a sufficient alternate power source such as a generator(s), maintained at the assisted living facility, to ensure that current licensees of assisted living facilities will be equipped to ensure air temperatures will be maintained at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. 1. The required temperature must be maintained in an area or areas, determined by the assisted living facility, of sufficient size to maintain residents safely at all times and that is appropriate for resident care needs and life safety requirements. For planning purposes, no less than twenty (20) net square per resident must be provided. The assisted living facility may use eighty percent (80%) of its licensed bed capacity as the number of residents to be used in the to determine the required square footage. This may include areas that are less than the entire assisted living facility if the assisted living facility's comprehensive emergency management plan includes allowing a resident to congregate when he or she desires in portions of the building where temperatures will be maintained and includes procedures for monitoring residents for signs of heat related injury as required by this rule. This rule does not prohibit a facility from acting as a receiving	A 200		

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A 200	Continued From page 3 provider for evacuees when the conditions stated in Section 408.821, F.S. and subsection 59A-36.019(5), F.A.C., are met. The plan shall include information regarding the area(s) within the assisted living facility where the required temperature will be maintained. 2. The alternate power source and fuel supply shall be located in an area(s) in accordance with local zoning and the Florida Building Code. 3. Each assisted living facility is unique in size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and staffing characteristics. Accordingly, this rule does not limit the types of systems or equipment that may be used to achieve temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. The plan shall include information regarding the systems and equipment that will be used by the assisted living facility and the fuel required to operate the systems and equipment. a. An assisted living facility in an evacuation zone pursuant to Chapter 252, F, S. must maintain an alternative power source and fuel as required by this subsection at all times when the assisted living facility is occupied but is permitted to utilize a mobile generator(s) to enable portability if evacuation is necessary. b. Assisted living facilities located on a single campus with other facilities under common ownership, may share fuel, alternative power resources, and resident space available on the campus if such resources are sufficient to support the requirements of each facility's residents, as specified in this rule. Details regarding how resources will be shared and any necessary movement of residents must be clearly	A 200		

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A 200	Continued From page 4	A 200		

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

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A 200	Continued From page 5 facility must develop a plan that includes maximum onsite fuel storage allowable by the ordinance or regulation and a reliable method to obtain the maximum additional fuel at least 24 hours prior to depletion of onsite fuel. (c) The acquisition of services necessary to maintain, and test the equipment and its functions to ensure the safe and sufficient operation of the alternate power source maintained at the assisted living facility. (d) The acquisition and maintenance of a monoxide alarm. (2) SUBMISSION OF THE PLAN. (a) Each new assisted living facility shall submit the plan required under this rule prior to obtaining a license. (b) Each existing assisted living facility that undergoes any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of its systems or equipment affecting the facility's compliance with this rule shall amend its plan and submit it to the county emergency management agency for review and approval. (3) APPROVED PLANS. (a) Each assisted living facility must maintain a copy of its approved plan in a manner that makes the plan readily available at the licensee's physical address for review by a legally authorized entity. If the plan is maintained in an electronic format, assisted living facility staff must be readily available to access and produce the plan. For purposes of this section, "readily available" means the ability to immediately produce the plan, either in electronic or paper format, upon request. (b) Within 30 days of the approval of the plan from the county emergency management agency, the assisted living facility shall submit in writing	A 200		

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	AL11969925	A. BUILDING: _____ B. WING _____	04/06/2026

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A 200	Continued From page 6 proof of the approval to the Agency for Health Care Administration to assistedliving@ahca.myflorida.com. (c) The assisted living facility shall submit a consumer-friendly summary of the emergency power plan to the Agency. The Agency shall post the summary and notice of the approval and implementation of the assisted living facility emergency power plans on its website within ten (10) business days of the plan's approval by the county emergency management agency and update within ten (10) business days of implementation. (4) IMPLEMENTATION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall, no later than , have implemented the plan required under this rule. (b) Each new assisted living facility shall implement the plan required under this rule prior to obtaining a license. (c) Existing assisted living facilities that undergo any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of the systems or equipment affecting the assisted living facility's compliance with this rule shall implement its amended plan concurrent with any such additions, modifications, alterations, refurbishment, renovations or reconstruction. (5) POLICIES AND PROCEDURES. (a) Each assisted living facility shall develop and implement written policies and procedures to ensure that the assisted living facility can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. The procedures shall ensure that residents do not experience complications from	A 200		

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A 200	Continued From page 7 fluctuations in air temperatures inside the facility. Procedures must address the care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury including: 1. The use of cooling devices and equipment; 2. The use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration; 3. Wellness checks by assisted living facility staff to monitor for signs of , and heat injury; and 4. A provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy. (b) Each assisted living facility shall maintain the written policies and procedures in a manner that makes them readily available at the licensee's physical address for review by a legally authorized entity. If the policies and procedures are maintained in an electronic format, assisted living facility staff must be readily available to access the policies and procedures and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce the policies and procedures, either in electronic or paper format, upon request. (c) The written policies and procedures must be readily available for inspection by each resident; each resident's legal representative, designee, surrogate, guardian, attorney in fact, or case manager; each resident's estate; and such additional parties as authorized in writing or by law. (6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this rule, the Agency for Health Care Administration may seek any remedy authorized by Chapter 429,	A 200		

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

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A 200	Continued From page 9 notifications, either in electronic or paper format, upon request. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain a working portable generator and have the required fuel for the operation of the alternate power source to maintain room temperatures at or below 81 degrees in the event of the loss of primary power for a minimum of 48 hours for five out five sampled residents. Findings: Based on observation on at 7:40 AM Staff B (Caregiver) was unable to start the Duro Max Hybrid II XP4400EH Generator due to a battery. Observation on at 7:43 AM Staff B unplugged the jump starter from the wall socket in the office and connected it to the battery post of the generator, but it did not start. Observation on at 7:44 AM found only four 15- . propane tanks for the generator which only can run the generator at 50% load for 37.5 hours. Interviewed on at 7:57 AM when informed that the generator was not starting, the Administrator stated that it was the generator battery and stated that the charger will charge for five minutes. Observation on at 12:49 PM the Administrator connected that jump starter to the generator and was unable to start the generator.	A 200		

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A 200	Continued From page 10 A review of Staff B's personnel records showed a hire date of and understanding facility's emergency environmental control plan training on . Class III	A 200		
AL241 SS=D	429.075( ); 59A-36.020(2) FAC LMH - Records 429.075 (3) A facility that has a limited mental health license must: (a) Have a copy of each mental health resident's community living support plan and the , agreement with the mental health care services provider or provide written evidence that a request for the community living support plan and the , agreement was sent to the Medicaid managed care plan or managing entity under contract with the Department of Children and Families within 72 hours after admission. The support plan and the agreement may be combined. (b) Have documentation provided by the department that each mental health resident has been assessed and determined to be able to live in the community in an assisted living facility that has a limited mental health license or provide written evidence that a request for documentation was sent to the department within 72 hours after admission. (c) Make the community living support plan available for inspection by the resident, the resident's legal guardian or health care surrogate, and other individuals who have a lawful basis for reviewing this document. (d) Assist the mental health resident in carrying out the activities identified in the resident's community living support plan.	AL241		

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AL241	Continued From page 11 (4) A facility that has a limited mental health license may enter into a , agreement with a private mental health provider. For purposes of the limited mental health license, the private mental health provider may act as the case manager. 59A-36.020 (2) RECORDS. (a) A facility with a limited mental health license must maintain an up-to-date admission and discharge log containing the names and dates of admission and discharge for all mental health residents. The admission and discharge log required in rule 59A-36.015, F.A.C., satisfies this condition provided that all mental health residents are clearly identified. (b) Staff records must contain documentation that designated staff have completed limited mental health training as required by rule 59A-36.011, F.A.C. (c) Resident records must include: 1. Documentation, provided by a mental health care provider within 30 days of the resident's admission to the facility, that the resident is a mental health resident as defined in section 394.4574, F.S., and that the resident is receiving social security , or supplemental security income and , , as follows: a. An affirmative statement on the Alternate Care Certification for , , ( ) form, CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No =Ref-03988, that the resident is receiving SSI or SSDI due to a mental , b. Written verification provided by the Social	AL241		

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AL241	Continued From page 12 Security Administration that the resident is receiving SSI or SSDI for a mental . Such verification may be acquired from the Social Security Administration upon obtaining a release from the resident permitting the Social Security Administration to provide such information, or c. A written statement from the resident's case manager or other mental health care provider that the resident is an adult with severe and persistent mental . The case manager or other mental health care provider must consider the following minimum criteria in making that determination: (I) The resident is eligible for, is receiving, or has received mental health services within the last 5 years, or (II) The resident has been diagnosed as having a severe or persistent mental . 2. An appropriate placement assessment provided by the resident's mental health care provider within 30 days of admission to the facility that the resident has been assessed and found appropriate for residence in an assisted living facility. Such assessment must be conducted by a psychiatrist, clinical psychologist, clinical social worker, , , nurse, or an individual supervised by one of these professionals. a. Any of the following documentation that contains the name of the resident and the name, signature, date, and license number, if applicable, of the person making the assessment, meets this requirement: (I) Completed Alternate Care Certification for , , ( ) form, CF-ES Form 1006, (II) Discharge Statement from a state mental hospital completed no more than 90 days before admission to the assisted living facility provided it contains a statement that the individual is	AL241		

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AL241	Continued From page 13 appropriate to live in an assisted living facility, or (III) Other signed statement that the resident has been assessed and found appropriate for residency in an assisted living facility. b. A mental health resident returning to a facility from treatment in a hospital or crisis stabilization unit will not be considered a new admission and will not require a new assessment. However, a break in a resident's residency that requires the facility to execute a new resident contract or admission agreement will be considered a new admission and the resident's mental health care provider must provide a new assessment. 3. A Community Living Support Plan. Each mental health resident and the resident's mental health case manager must, in consultation with the facility administrator, prepare a plan within 30 days of the resident's admission to the facility or within 30 days after receiving the appropriate placement assessment in paragraph (2)(c), whichever is later, that: a. Includes the specific needs of the resident that must be met in order to enable the resident to live in the assisted living facility and the community, b. Includes the clinical mental health services to be provided by the mental health care provider to help meet the resident's needs, and the frequency and duration of such services, c. Includes any other services and activities to be provided by or arranged for by the mental health care provider or mental health case manager to meet the resident's needs, and the frequency and duration of such services and activities, d. Includes the ˬ of the facility to facilitate and assist the resident in attending . . and arranging transportation to . . for the services and activities identified in the plan that have been provided or arranged for by the resident's mental health care	AL241		

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AL241	Continued From page 14 provider or case manager, e. Includes a description of other services to be provided or arranged by the facility, f. Includes a list of factors pertinent to the care, safety, and welfare of the mental health resident and a description of the signs and symptoms , to the resident that indicate the immediate need for professional mental health services, g. Is in writing and signed by the mental health resident, the resident's mental health case manager, and the assisted living facility administrator or manager and a copy placed in the resident's file. If the resident refuses to sign the plan, the resident's mental health case manager must add a statement that the resident was asked but refused to sign the plan, h. Is updated at least annually or if there is a significant change in the resident's behavioral health, i. , include the , Agreement described in subparagraph (2)(c)4. If included, the mental health care provider must also sign the plan; and, j. Must be available for inspection to those who have legal authority to review the document. 4. , Agreement. The mental health care provider for each mental health resident and the facility administrator or designee must prepare a written statement, within 30 days of the resident's admission to the facility or receipt of the resident's appropriate placement assessment, whichever is later. The statement: a. Provides procedures and directions for accessing emergency and after-hours care for the mental health resident. The provider must furnish the resident and the facility with the provider's 24-hour emergency crisis telephone number;	AL241		

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AL241	Continued From page 15 b. Must be signed by the administrator or designee and the mental health care provider, or by a designated representative of a Medicaid prepaid health plan if the resident is on a plan and the plan provides behavioral health services in section 409.912, F.S.; c. , cover all mental health residents of the facility who are clients of the same provider; and, d. , be included in the Community Living Support Plan described in subparagraph (2)(c)3. 5. Missing documentation will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the appropriate party. A documented request for such missing documentation made by the facility administrator within 72 hours of the resident's admission will be considered a good faith effort. The documented request must include the name, title, and phone number of the person to whom the request was made and must be kept in the resident's file. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility with a limited mental license failed to maintain and updated admissions and discharge log containing the names and dates for all mental health residents were clearly identified for two (Residents #3 & #5) out of eight sampled residents. Findings: Observation on at 6:40 AM found Residents #3, and #5 in the facility. A review of Resident #3's records found a community living support plan and , , agreement dated .	AL241		

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AL241	Continued From page 16 A review of the admissions and discharge log showed Resident #3 was admitted on . However, there was no indication she was a mental health resident. A review of Resident #5's records found a community living support plan and , agreement dated . A review of the admissions and discharge log showed Resident #5 was admitted on . However, there was no indication he was a mental health resident. Interviewed on at 12:15 PM the Administrator acknowledged that they were not listed and stated further, "Okay." Class III	AL241		
A 000	Initial Comments A standard survey was conducted at NOA ALF LLC from 0323/2026 through . Deficiencies were identified at the time of the survey. Class I deficiencies were identified at Tags: A0025, A0030, and A0078. A class I deficiency is a deficiency that the agency determines present situation in which immediate corrective action is necessary because the facility's non-compliance has caused, or is likely to cause, serious injury, harm, , , or to a resident receiving care in a facility. The Class I noncompliance began on ,	A 000		

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A 000	Continued From page 17 , and . The facility's Administrator was notified of the Class I noncompliance on and . The census at the start of the survey was 5 residents. The following is a description of the deficiencies found at the time of the visit: A0025, A0030, A0036, A0052, A0053, A0055, A0077, A0078, A0092, A0093, A0152, A0160, A0162, A0165, A0180, A0200, AL241, ZZ875	A 000		
A 025 SS=L	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the	A 025		

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A 025	Continued From page 18 condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses 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 record reviews and interviews, the facility failed to provide supervision and ensure daily observation for four (#1, #2, #4, #8) out of eight sampled residents, including their activities	A 025		

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A 025	Continued From page 19 of daily living while on premises, and awareness of their general health and safety. The facility failed to ensure Staff B (Caregiver) provide care and services appropriate to the needs of Resident #1. Residents #1, # 2, and #8 were found unresponsive and later pronounced . The facility failed to become aware Resident #4 was placed under Baker from their facility. Findings: 1) A review of Resident #1's emergency medical records ( ) dated documented that the resident was found on the floor unresponsive, without a and not breathing and on rate monitor, to touch with stiff elbows that kept arms up and stiff , and that kept outward. Interviewed on at 10:05 AM the hospice nurse stated that Resident #1 had a do not order ( ) dated and was bedridden. However, Staff B provided ( ) and disregarded the order. Interviewed on at 11:20 AM Staff B stated that he provided on Resident #1 whether he was wrong or not even though she had a in her chart. A review of Resident #1's records found no interdisciplinary hospice care plan, a and an updated health assessment for Staff B to provide care and services appropriate to the needs of the resident. Interviewed on at 12:15 PM the	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969925	A. BUILDING: _____ B. WING _____	04/06/2026

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A 025	Continued From page 20 Administrator stated that Resident #1 had a . The Administrator stated further that the hospital did not provide her hospice records and was waiting for them. Interviewed on at 2:54 PM Staff C (Caregiver) stated that the resident , , under hospice. Staff C stated that it was a natural . Staff C stated that she was two days under hospice care and they did not received the until after she , , . Staff C stated further that the came from hospice and that she did not have a before. 2) A review of Resident #2's records dated showed resident #1 was found unresponsive and without a , and patient was , and had livor mortis with slight pooling notes and stiff around the jaw and -on arrival at 10:35 AM. A review of Resident #2's progress notes dated documented the resident was found unresponsive, was performed and she . The Administrator documented further that Resident #2's power of attorney was notified. However, there was no documentation of the time and date the resident was found unresponsive, where she was found, whether she was in bed and if she received breakfast and medications. A review of Resident #2's police report dated revealed: "I was dispatched to the listed location in emergency mode reference an unresponsive , . Upon arrival I observed the caretaker reporting person [Staff B] attempting to perform on Resident #2]. [Fire Resue] pronounced victim at 10:45 AM.	A 025		

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A 025	Continued From page 21 Reporting person [Staff B] advised he gave the patient her morning medication at 7:00 AM and that was the last time he saw her awake. Patient's body was located on the floor facing westbound, facing east bound. Reporting person [Staff B] advised he moved her from the bed to the floor in order to perform . Upon arrival victim [Resident #2] was already to touch and showing signs of rigamortus." A review of Resident #2's health assessment dated showed diagnoses of displaced intertrochateric of left , subsequent encounter for closed with routine healing. The activities of daily living showed assistance needed with ambulation, bathing, , eating, self-care, toileting and transferring. 3) Interviewed on at 11:20 AM when asked about Resident #8, Staff B (Caregiver) stated that the resident was found on the floor unresponsive around 10:30 PM on . Staff B stated further that Resident #8 in the facility. However, the Administrator and Staff C were unaware the resident in the facility. Interviewed on at 12:15 PM the Administrator stated Resident #8 had vital signs and that the resident was transported to the hospital. Interviewed on at 2:54 PM Staff C (Caregiver) stated that Resident #8 was found unresponsive, but Staff C stated that at the time he left with rescue, he was responsive but in the care of rescue. A review of Resident #6's progress notes dated	A 025		

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A 025	Continued From page 22 the Administrator wrote that when the hospital was called that was when they found out the resident was . A review of the police report dated revealed: "Upon arrival, fire rescue was already [arrived] conducting . , ( ). They advised [they were] going to transport him to the [hospital]. Homicide was notified and advised to release [Resident #8] to hospital while [detective] is in the process of locating next of kin for Resident #8]." 4) A review of Resident #4's police report dated revealed: I was dispatched to the listed location reference a male telling him to kill himself. Upon arrival, contact was made with reporting person [Staff B Caregiver] the assisted living manager. He stated that other [Resident #4] a patient in the ALF, has been depressed lately and hasn't been himself. He stated that other [Resident #4] advised him of voices and what they were telling him to do. We also made contact with other [Resident #4] who is diagnoses with . and is currently on medication. Other [Resident #4] stated that the voices were telling him to kill himself, and that he's had thoughts. He further stated that he's been very depressed lately and wanted help. Other [Resident #4] was and taken to [Clinic] for further evaluation. Without care or treatment, it is likely that other [Resident #4] will harm himself." However, the Administrator stated that the resident was not placed under . Interviewed on at 2:36 PM when asked if anyone was placed under , the administrator stated, "No."	A 025		

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A 025	Continued From page 23 When asked if Resident #4 was placed under , the Administrator stated that the police was called but the resident was not taken. When asked about the police coming to the facility on , the Administrator stated that she does not remember. Class I	A 025		
A 030 SS=J	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; _ Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline,	A 030		

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A 030	Continued From page 24 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; 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	A 030		

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A 030	Continued From page 25 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 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	A 030		

Agency for Health Care Administration

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A 030	Continued From page 26 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 , , 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	A 030		

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A 030	Continued From page 27	A 030		

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.

(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

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A 030	Continued From page 28 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 facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure five out of eight sampled residents live in a safe and decent living environment, free from and neglect and be treated with consideration and respect. Staff B (Caregiver) failed to respect the rights of Resident #1 who wished not to be	A 030		

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A 030	Continued From page 29	A 030		

after being found unresponsive and performed , , ( ). Staff B failed to respect the right to privacy for Resident #3. The facility also failed to prevent residents from smoking inside the facility.

Findings:

1)

A review of Resident #1's emergency medical records ( ) dated revealed: "[Resident #1] was found on the floor pulseless and not breathing and , on the rate monitor, to touch, stiff elbows that kept her arms up and stiff , and that kept outward."

Interviewed on at 11:20 AM when asked what happened to Resident #1, Staff B Caregiver stated that the resident was hospice. Staff B stated that she had a . Staff B stated, "She was an elderly person." Staff B stated that he was a nurse in [his country]. Staff B stated, "She had a event." When asked if the resident had a ( ), Staff B stated that he still did ( ) whether he was wrong or not. Staff B stated that he called 911 and that they asked him to start . Staff B stated that he knew she had an order. Staff B stated that he put Resident #1 on the floor. Staff B stated, "I complied with the instructions from 911 to do . The order was in the chart." However, a review of Resident #1's records found no hospice care interdisciplinary plan, including a .

Interviewed on at 10:23 AM the hospice nurse confirmed Resident #1 had a signed dated , and she was

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A 030	Continued From page 30 bedridden and a hospital bed was delivered. A review of Resident #1's progress notes dated documented by the Administrator stated that they were doing rounds around 12:35 AM when they realized the resident not responding to stimulus and 911 was called. The Administrator documented that rescue was called when the resident was found unresponsive. Interviewed on at 12:15 PM when asked if Resident #1 had a , the Administrator stated that Resident #1 had a . The Administrator stated that the hospital did not provide her hospice records. The Administrator stated that Resident #1 was under [hospice care] and at the time when she , , and she (Administrator) did not have the records in the facility and was waiting for her records. The Administrator said, "I understand." According to Florida Health, " is a form or patient identification device developed by the Department of Health to identify people who do not wish to be in the event of , , or ." 2) Observation on at 7:00 AM Resident #3 was in bed, and there was no smoke or smell of cigarettes. Observation on at 7:01 AM found a second bed in the room, which appeared unmade and someone slept in it. Interviewed on at 7:01 AM when asked if she had a roommate, Resident #3 stated that Staff B (Caregiver) slept in it.	A 030		

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A 030	Continued From page 31 Observation on at 7:24 AM Resident #3's room had an odor of what appeared to be cigarette smoke. Observation on at 7:45 AM Staff B exited # after using bathroom. Interviewed on at 7:24 AM if she was smoking in the room, Resident #3 denied that she was smoking in the room. Interviewed on at 12:15 PM when informed Staff B was sleeping in a resident's room, the Administrator stated that he had his own room. Class I	A 030		
A 036 SS=D	59A-36.007(10) CONTROL PROCEDURES (10) CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of (a) The facility must implement a hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or , . hygiene may include the use of -based rubs, , handwash, or handwashing with soap and water. (b) Standard precautions must be used when there is an , exposure to transmissible agents in , , , , , nonintact skin, and mucuous during the provision of personal services. Standard precautions include:	A 036		

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A 036	Continued From page 32 hygiene, and dependent upon the exposure, use of gloves, gown, mask, , protection, or a shield. (c) The facility must clean and reusable medical equipment and communal assistive devices that have been designed for use by multiple residents before and after each use according to the manufacturer's recommendations. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure Staff B (Caregiver) provide services in a manner that reduces the risk of transmission of for four (#3, #5, #6, & #7) out of eight sampled residents. Findings: Observation on at 8:23 AM Staff B offered medications to Resident #7 a touched each tablet before offering them to the resident. Observation on at 8:30 AM without changing gloves and washing after Resident #7 touched each tablet and offered them to Resident #5. Observation on at 9:06 AM without changing gloves and washing after Resident #5 touched each tablet and offered them to Resident #3. Observation on at 9:15 AM without changing gloves and washing after Resident #3 touched each tablet and offered them to Resident #6. Interviewed on at 12:15 PM the	A 036		

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A 036	Continued From page 33 Administrator acknowledged that the staff did not wash and change gloves between residents. The Administrator stated further, "Okay." A review of Staff B's personnel records showed a hire date of and control training on . A review of the facility's control policy reveals: "All employees having direct contact with residents and or material that can directly affect the life and safety of the resident will observe universal precautions. The practice is to minimize or prevent exposures of health care workers and residents to bloodborne , . Procedure for medication assistance with self-administration with medication: washing is required before and after assistance with medication." Class III	A 036		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication	A 052		

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A 052	Continued From page 34 name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , , converting, or , medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a , of the body. (d) Administration of , preparations. (e) The use of irrigations or debriding agents	A 052		

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A 052	Continued From page 35 used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident	A 052		

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A 052	Continued From page 36 to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the	A 052		

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A 052	Continued From page 37 terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure Staff B (Caregiver) orally advise three out of eight sampled residents who needed assistance with self-administration medication of the names and dosages of each medication offered. Staff B failed to observe the residents swallowing the medications before initialing the medication observation record. The facility failed to ensure Resident #6 received or was offered medications at the time prescribed by health care provider. Findings: Observation on at Staff B popped the following medications from the packs: , 0.5 MG, 25 MG, , 12.5 MG, 10 MG, and , , 5 MG and offered them to Resident #7 without naming each medication and dosage and observing the resident swallow. A review of Resident #7's health assessment dated showed she needed assistance with self-administration of medication. A review of Resident #7's records found no medication waiver to opt of being orally advised of the name of the medications and dosage.	A 052		

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A 052	Continued From page 38 Observation on at 8:30 AM Staff B offered medications to Resident #5 without naming the medications and dosage and observing the resident swallow the medications. A review of Resident #5's health assessment dated showed the resident needed assistance with self-administration of medication. A review of Resident #5's records found no medication waiver to opt out being orally advised the name and dosage of the medications offered. A review of the medication observation record (MOR) for Resident #6 revealed medications prescribed for 8:00 AM. Observation on at 9:15 AM showed Resident #6 received medications offered by Staff B without naming the medication and dosage. A review of Resident #6's records found no medication waiver to opt out of being orally advised of the name and dosage. A review of Resident 6's health assessment dated showed the resident needed assistance with self-administration of medication. Interviewed on at 12:15 PM the Administrator acknowledged that the staff did not name the medication and dosage and give the medication on time. A review of Staff B's personnel records showed a hire date of and six (6) hours of assistance with self-administration of medication training on . Class III	A 052		

Agency for Health Care Administration

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A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to maintain an updated medication observation record (MOR) for one (Resident #7) out of eight sampled residents with	A 054		

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A 054	Continued From page 40 the know ␣ , name of health care provider and provider's telephone number. Findings: Observation on at 8:23 AM Staff B (Caregiver) offered medications to Resident #7. A review of Resident #7's health assessment dated showed the resident needed assistance with self-administration of medications. A review of Resident #7 MOR showed no listed ␣ , and the name of a health care provider's telephone number. Interviewed on at 12:15 PM the Administrator stated that the resident was in the middle of changing doctors. Class III	A 054		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter	A 055		

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A 055	Continued From page 41 medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other	A 055		

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A 055	Continued From page 42 residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to return all medications to one (Resident #8) out of eight sampled residents, to his family or guardian after a resident's stay has ended. The facility failed to	A 055		

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A 055	Continued From page 43 centrally store prescribed medications in a locked cabinet or closet for one (Resident #3) out eight sampled residents. Findings: Observation on at 7:04 AM found medications (3 boxes of True Metrix Test Strips, 1 o of 100 sterile single use lancets 30 gauge) prescribed for Resident #8 in a white bag who was discharged from the facility on after he was found unresponsive. Photographic evidence obtained. Observation on at 7:05 AM found a white bottle of 10 GM/15ML solution prescribed for Resident #3. Observation at 7:11 AM found unlocked medications in the kitchen cabinet including a spray can of simply sterile solution for wash, and two jars of skin protectant. Interviewed on at 12:15 PM when informed there were unlocked medications found, the Administrator stated, "Where?" A review of the facility's medication storage policy states all medications will be locked. Class III	A 055		
A 077 SS=G	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	A 077		

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A 077	Continued From page 44 must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is 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.;	A 077		

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A 077	Continued From page 45 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to , . , are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core 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	A 077		

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A 077	Continued From page 46 administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that it was under the supervision of an Administrator who ensured safety and the provision of appropriate care of all residents. The Administrator failed to file five adverse incidents, including three deaths in the facility and a resident with . The Administrator	A 077		

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A 077	Continued From page 47 failed to maintain Resident #1's hospice records onsite after less than a year after discharge. The Administrator failed to be aware of an incident on where police were on scene. The facility Administrator failed to explain a smashed windowpane. Findings: Interviewed on at 12:15 PM when informed of adverse incidents on , , and when the police and rescue were called and not filed, the Administrator stated that the employee called 911 and rescue called the police and that was the reason for not filing. When asked about Resident #8, the Administrator stated that Resident #8] had vital signs and that he was transported to the hospital. The Administrator stated that Resident #2 did not have a . The Administrator stated that Resident #1 had a . However, Staff B (Caregiver) stated that he performed on on the floor in an interview on at 11:20 AM. Interviewed on at 12:15 PM when asked if Resident #1 had hospice care records including a on file, the Administrator stated she did not have a onsite for Resident #1. The Administrator stated that the hospital did not provide Resident #1's hospice records. Interviewed on at 12:15 PM when informed of the broken windowpane, the Administrator only stated that she was going to repair the missing knobs to the shower in # .	A 077		

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	AL11969925	A. BUILDING: _____ B. WING _____	04/06/2026

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A 077	Continued From page 48 Interviewed on at 2:36 PM when asked about an incident involving the police at the facility on , the Administrator stated that she did not know. When asked about any residents being placed under , the Administrator stated that no one was. When informed that a resident was placed under on , the Administrator stated, "No." When asked if Resident #4 was placed under , the Administrator stated that the police and that the resident was not taken. However, a review of Resident #4's police report dated revealed that the resident was taken under to [a Clinic] for further evaluation. Class II	A 077		
A 078 SS=K	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual	A 078		

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A 078	Continued From page 49 examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and,	A 078		

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A 078	Continued From page 50 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure two (Staff B & C Caregivers) out of four sampled employees could describe , ( ) techniques and comply with a ( ) consistent with their level of education, training, preparation, and experience. Staff B failed to demonstrate capabilities to perform on two (2) residents (Residents #2 & #8) found unresponsive and pronounced . Staff B performed on Resident #1 who was found unresponsive and wished not to be . Findings: 1) A review of Resident #1's emergency medical records ( ) dated revealed the resident was found on the floor without a , not breathing and , on the monitor, to touch with stiff elbows that kept arms up and stiff , that kept outward. Interviewed on at 11:20 AM when asked what happened to Resident #1, Staff B stated the resident had a and the resident was under hospice care and had a in her chart. Staff B stated that he placed the resident on the floor and started whether he was wrong or not. Staff B stated that he complied with the instructions to do after he	A 078		

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A 078	Continued From page 51 called 911. However, Staff B obtained training on and training on and had a hire date of . Interviewed on at 10:23 AM hospice nurse stated that Resident #1 had a dated and that she was bedridden. 2) A review of Resident #2's Emergency Medical Services records dated showed the resident was found unresponsive and without a , with livor mortis and slight pooling and stiff around the jaw. A review of Resident #2's progress notes dated documented Staff B performed . Interviewed on at 11:20 AM when asked to describe , Staff B stated that he would check for vital signs and check for and then four , for every breath. When asked what happened to Resident #2, Staff B stated that the resident went to the hospital twice before this incident. Staff B stated further that the resident was found unresponsive and he did and she in the house. 3) A review of Resident #8's progress notes dated documented Staff B performed on the resident. However, a review of Resident #8's police report dated showed when police arrived, was being done by and did not document any actions of performed by Staff B. Interviewed on at 12:15 PM the	A 078		

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A 078	Continued From page 52 Administrator stated that Resident #1 had a and Resident #2 and #8 did not have a . The Administrator stated further that Resident #1 had vital signs and was transported to the hospital and did not in the house. 4) Observation on at 6:55 AM found a census of five residents in the facility who wished to be in the facility in the event if they become unresponsive and Staff B alone with them. A review of the facility's staffing pattern dated showed Staff C (Caregiver) worked from 7:00 AM-7:00 PM. Interviewed on at 2:54 PM when asked to describe , Staff C stated that he would perform the procedure when there was no breathing and no , . Staff C stated that he would do 30 or 31 , and one breath. Staff C stated that he would not stop until rescue arrived. According to the American Association, "For healthcare providers and those trained: conventional using , and -to- breathing at a ratio of 30:2 , -to-breaths." According to Florida Health, " is a form or patient identification device developed by the Department of Health to identify people who do not wish to be in the event of , , or " Class I	A 078		

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A 092	Continued From page 53	A 092		
A 092 SS=D	59A-36.012(1) FAC Food Service - General Responsibilities (1) GENERAL RESPONSIBILITIES. When food service is provided by the facility, the administrator, or an individual designated in writing by the administrator, must be responsible for total food services and the day-to-day supervision of food services staff. In addition, the following requirements apply: (a) If the designee is an individual who has not completed an approved assisted living facility core training course, such individual must complete the food and nutrition services module of the core training course before assuming responsibility for the facility's food service. The designee is not subject to the 1 hour in-service training in safe food handling practices. (b) If the designee is a certified food manager, certified dietary manager, registered or licensed dietitian, dietetic registered technician, or health department sanitarian, the designee is exempt from the requirement to complete the food and nutrition services module of the core training course before assuming responsibility for the facility's food service as required in paragraph (1)(a) of this rule. (c) An administrator or designee must perform his or her duties in a safe and sanitary manner. (d) An administrator or designee must provide regular meals that meet the nutritional needs of residents, and therapeutic diets as ordered by the resident's health care provider for residents who require special diets. (e) An administrator or designee must comply with the food service continuing education requirements specified in rule 59A-36.011, F.A.C. This Statute or Rule is not met as evidenced by:	A 092		

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A 092	Continued From page 54 Based on observation, record review and interview, the facility failed to ensure the Administrator performed his or her duties in a safe and sanitary manner for five out five sampled residents. Findings: Observation on at 7:10 AM found in the freezer: half lion roast with a use or freeze by date of , a half of lion roast use or freeze by date, and a beef inside skirt sell by . Photographic evidence obtained. Interviewed on at 12:15 PM the Administrator acknowledged the meat in the freezer. A review of the Administrator's personnel records showed a hire date of and two hours of continuing education training on nutrition and food service/food design training on . Class III	A 092		
A 093 SS=I	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the	A 093		

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A 093	Continued From page 55 National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic	A 093		

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A 093	Continued From page 56 diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any	A 093		

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A 093	Continued From page 57 resident, must be on . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to post an accurate an updated menu reflecting the week of through accessible to five out of five sampled residents. The facility failed to ensure adequate and sufficient foods including snacks were available and accessible for five out five sampled residents. Findings: Observation on at 6:55 AM found five residents in the facility. Observation on at 7:08 AM found a menu posted for the week of through . Photographic evidence obtained. Observation on at 7:09 AM found a refrigerator accessible to the residents with only a bag of lettuce and no milk, fruits, juices or available snacks displayed on top of the counter or in the cabinets. Observation on at 07:10 AM found a	A 093		

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A 093	Continued From page 58 2nd refrigerator locked in an office and not accessible to the residents contained: ½ gallon milk, 1 jar mayonnaise ,1 six pack of non- Malta, 1 can tomato paste, 3 1-liter bottles of soda, and 2 boxes of sugar cane cubes. Interviewed on at 7:10 AM Staff B (Caregiver) stated that the food belonged in the refrigerator in the office belonged to the residents. Observation on at 8:32 AM grocery being delivered to house, including gallons of milk and juices. Interviewed on at 12:15 PM when informed of the insufficient food, the Administrator stated, "Okay." According to the American Association (AHA), the suggested number of servings for each food group as follows: " Five servings per day of vegetables (fresh, canned, and dried) " Four servings per day of fruits (fresh, canned and dried) " Six servings per day of grains (at least ½ should be whole grain/high in dietary) " Three servings per day of dairy (low-fat-free) " Between eight to nine serving per week of poultry, meat and eggs. " Between two to three servings per week of fish and other seafood (preferably oily fish that provide omega-three fatty acids) " Five servings per week of nuts, seeds, beans, and legumes " Three servings per day of fats and oils (preferably unsaturated). A review of the Administrator's personnel records	A 093		

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A 093	Continued From page 59 showed a hire date of and two hours of continuing education training on nutrition and food service/food design training on . Class II	A 093		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside	A 152		

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A 152	Continued From page 60 commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . . . . This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a safe and living environment free of hazards for five out of eight sampled residents. Findings: Observation on at 6:50 AM found front windowpane broken and exposed. Photographic evidence obtained. Observation on at 6:57 AM what appeared to be excessive dust on light shade of bathroom ceiling in main hallway. Observation on at 7:00 AM found hot and -water knobs missing from bathroom shower in # and rust around lighting fixture. Interviewed on at 7:24 AM when asked about her ability to shower with the missing knobs, Resident #3 stated that she used the bathroom in the main hallway to shower. Observation on at 7:05 AM missing drawer from kitchen cabinet. Observation on at 7:08 AM missing lamp from # .	A 152		

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A 152	Continued From page 61 Observation on at 7:15 AM found three tubes of , USP 2% accessible to Resident #4 in employee's room. Interviewed on at 7:15 AM Staff B stated that the medications belonged to him. Observation on at 7:22 AM cracked bathroom tiles main hallway. Observation on at 7:21 AM found broken glass on the windowsill in the common area. Interviewed on at 7:21 AM Staff B (Caregiver) stated that someone broke the window. Observation on at 7:26 AM found hole in drywall in # . Observation on at 7:34 AM found rotted wood at the rear of the house soffit. Interviewed on at 12:15 PM the Administrator acknowledged that the knobs needed fixing and repairs needed to be done. Class III	A 152		
A 160 SS=D	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce	A 160		

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	AL11969925	A. BUILDING: _____ B. WING _____	04/06/2026

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NOA ALF LLC	14335 SW 288TH ST HOMESTEAD, FL 33033

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A 160	Continued From page 62 the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a , , ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission 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	A 160		

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A 160	Continued From page 63 Rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by Section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 59A-36.007, F.A.C. (j) All food service records required in Rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's 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.;	A 160		

Agency for Health Care Administration

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A 160	Continued From page 64 (q) The facility's prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.; (w) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain an updated annual sanitation inspection report provided by the department of health. The Administrator failed to ensure a written notice of rights, , and prohibitions set forth in this part is posted in a prominent place, including the Elder Hotline operated by the Department of Children and Families toll free number. The facility failed to provide bank statements for the past three months. Findings: A review of the posted annual sanitation report showed it was expired ( ) provided by the health department. A review of the facility's bulletin board found no information posted and toll-free number of the Elder operated by the Department of Children and families. Interviewed on at 12:15 PM the Administrator stated that she called the health	A 160		

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A 160	Continued From page 65 department. Interviewed on at 2:26 PM when asked to provide bank statements for the past three months (, and , the Administrator stated that she would. Interviewed on at 1:37 PM the Administrator stated that she sent the statements to the office. Class III	A 160		
A 162 SS=D	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,	A 162		

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A 162	Continued From page 66 therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A ◡ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their ◡ recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that ◡ not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust	A 162		

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A 162	Continued From page 67 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 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	A 162		

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A 162	Continued From page 68 contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to maintain an accurate and complete health assessment for three out of eight sampled residents, including retaining records for two years after discharge. The facility failed to semi-annually record the ᵕ record for Resident 5 who needed assistance with activities of daily living. Findings: Observation on at 8:20 AM Resident #5 ambulated with cane to common area. A review of Resident #5's health assessment dated showed a diagnoses of ', ', ,', ,', , right side ', ᵕ ', ', unsteady gait, and 's . The resident had and precautions. The activities of daily living showed independent with ambulation (cane), eating, toileting, and supervision with transferring, and assistance needed with bathing, ᵕ, and self-care. A review of Resident #5's records found no ᵕ log records, which recorded his ᵕ semi-annually for 2025.	A 162		

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A 162	Continued From page 69 A review of the admissions and discharge log showed an admission date of . A review of Resident #6's health assessment dated showed a diagnoses of psych. , , and . The status showed the resident had precautions. The activities of daily living showed independent with ambulation, bathing, , eating, self-care, toileting, and transferring. However, the physical status and the and of section #1 was left blank. A review of the admissions and discharge log showed a discharge date for Resident #1 on . A review of Resident #1's hospice records found no interdisciplinary hospice care plan and a for the resident. Interviewed on at 12:15 PM the Administrator acknowledged that the health assessment and log were left blank and incomplete. The Administrator stated further, "Okay." The Administrator stated further that she did not have Resident #1's hospice records and that the hospital did not provide it. Class III	A 162		
A 165 SS=E	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality	A 165		

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A 165	Continued From page 70 assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident.	A 165		

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A 165	Continued From page 71 (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary	A 165		

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A 165	Continued From page 72 proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to file five (5) adverse incidents reports for four (Resident #1, #2, #) out of eight sampled residents after emergency medical services and the police were called for unresponsive residents and a resident with . The facility failed to file adverse incidents reports within one business day of the occurrence through the agency's online portal and within 15 days a completed report. Findings: 1) A review of Resident #8's progress notes dated documented that Resident # 8 was found unresponsive, 911 was called and transported to the hospital. A review of the police department calls for service showed a police case number on as on arrival. A review of the adverse incidents reporting systems database found no reports on Resident #8 being found unresponsive. A review of Resident #8's health assessment dated showed the resident was not under hospice care. 2)	A 165		

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A 165	Continued From page 73 A review of emergency medical services ( ) records dated showed Resident #1 was found on the floor pulseless and not breathing, to touch, stiff elbows that kept arms up and stiff that kept outwards. A review of the adverse incidents database reporting systems showed no reports of an adverse incident of Resident #1 found unresponsive and in the facility, including ( ) being performed on a resident with a A review of the police department calls for service showed a police case number on for sick or injured person. 3) A review of a police report dated 11/05/2025 showed Resident #4 was placed under after feeling depressed and and expressing thoughts. A review of the adverse incidents reporting systems database found no reports on Resident #8 expressing and the police being called as a result. A review of the police department calls for service showed the police were on scene on for . 4) A review of Resident #2's records dated found the resident unresponsive and without a and had livor mortis.	A 165		

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A 165	Continued From page 74 A review of Resident #2's police report dated showed the resident was pronounced on the scene. A review of Resident #2's health assessment dated showed the resident was not under hospice care. A review of the adverse incident reporting systems showed no reports file for Resident #2 being pronounced in the facility and not under hospice care. Interviewed on at 12:15 PM when informed of adverse incidents when the police and rescue were called, the Administrator stated that the employee called 911 and rescue called the police and that was the reason for not filing. When asked about Resident #8, the Administrator stated that Resident #8] had vital signs and that he was transported to the hospital. The Administrator stated that Resident #2 did not have a . The Administrator stated that Resident #1 had a . 5) A review of the calls for services on showed a police case number to conduct investigation. Interviewed on at 2;36 PM when asked about the police at the facility on the Administrator stated that she did not remember. Class III	A 165		