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
	AL11953207	A. BUILDING: _____ B. WING _____	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE POINTE AT WEST PALM	145 EXECUTIVE CENTER DRIVE WEST PALM BEACH, FL 33401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced Relicensure, Complaint (#2026006678) and Generator Monitoring survey was conducted on at The Pointe At West Palm. The facility had deficiencies related to the Relicensure at the time of survey.	A 000		
A 032	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all	A 032		

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A 032	Continued From page 1 facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on interviews and record reviews, it was determined that the facility failed to provide documentation of staff participation in elopement drills conducted for 5 out of 7 sampled staff (Staff A, B, C, G and J) The findings included:	A 032		

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A 032	Continued From page 2 During an interview on at 8: 41 AM, the Administrator was asked to provide documentation for the facility's elopement drills conducted twice a year for 2024 and 2025. 1) Review of the facility's personnel file for Staff A (Administrator) with hire date of revealed Staff A had no documentation of participating in elopement drills twice a year for 2025. 2) Review of the facility's personnel file for Staff B (Med-Tech) with hire date of revealed Staff B had no documentation of participating in elopement drills twice a year for 2024 and 2025. 3) Review of the facility's personnel file for Staff C (Caregiver) with hire date of revealed Staff C had no documentation of participating in elopement drills twice a year for 2024 and 2025. 4) Review of the facility's personnel file for Staff G (Caregiver/Med-Tech) with hire date of revealed Staff G had no documentation of participating in elopement drills twice a year for 2024 and 2025. 5) Review of the facility's personnel file for Staff J (Health Services Director/LPN) with hire date of revealed Staff J had no documentation of participating in elopement drills twice a year for 2025. During an interview with the Administrator on at 1:25 PM she was informed that direct care Staff A, B, C, G and J did not participate in elopement drills for 2024 and 2025. The Administrator acknowledged the findings mentioned above.	A 032		

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A 032	Continued From page 3 Class III	A 032		
A 078	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience.	A 078		

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A 078	Continued From page 4 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 ˬ to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and an interview, it was determined that the facility failed to ensure 1 out of 5 sampled employees (Staff C) had submitted a written statement from a health care provider documenting that the employee does not have any signs or symptoms of communicable dated within six months prior to hire; and, failed to ensure 1 out of 5 sampled employees (Staff C) submitted an annual negative ( )	A 078		

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A 078	Continued From page 5 statement by a health care provider. The findings included; A record review of Staff C's (Resident Assistant) personnel file with a date of hire , who provides direct care to residents revealed no documentation of a written statement from a health care provider documenting that this staff member was free from any signs and symptoms of communicable , including . Further review revealed no documentation of negative examination completed on an annual basis for years 2023, 2024, and 2025 The Administrator was notified of these findings on at approximately 4:30 PM. The facility provided no additional documentation of the required statements for review at this time. Class III	A 078		
A 081	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee ' s personnel record.	A 081		

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A 081	Continued From page 6 (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by	A 081		

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A 081	Continued From page 7 the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . . . The facility must use its	A 081		

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A 081	Continued From page 8 prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and an interview, it was determined that the facility failed to ensure 4 out of 5 sampled direct care staff (Staff B, C, D, and J) had completed the required in-service trainings.	A 081		

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A 081	Continued From page 9 The findings included; A Record review of Staff B's (Medication Assistant) personnel file with a hire date of revealed no documentation of attending the required 2-hour Pre Service Orientation prior to interacting with residents. Further review revealed no documentation of the required in-service training within 30 days of employment on the facility's resident elopement response policies and procedures. A Record review of Staff C's (Resident Assistant) personnel file with a hire date of revealed no documentation of attending the required 2-hour Pre Service Orientation prior to interacting with residents. Further record review revealed no documentation of the required in-service training within 30 days of employment on Reporting Major Incidents, Adverse Incidents, Facility Emergency Procedures, Incident Reporting. A Record review of Staff D's (Resident Assistant) personnel file with a hire date of revealed no documentation of attending the required 2-hour Pre Service Orientation prior to interacting with residents. Further record review revealed no documentation of the following required in-service trainings within 30 days of employment, 1) Reporting Major Incidents, Adverse Incidents, Facility Emergency Procedures, Incident Reporting 2) Resident Rights in an assisted living facility 3) Facility's resident elopement response policies and procedures. A Record review of Staff J's (Health Services	A 081		

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A 081	Continued From page 10 Director) personnel file with a hire date of revealed no documentation of attending the required 2-hour Pre Service Orientation prior to interacting with residents. Further record review revealed no documentation of the required in-service training within 30 days of employment on the facility's resident elopement response policies and procedures. During an interview conducted on at approximately 4:30 PM the Administrator confirmed that all the personnel files lacked documentation on the required in-service training and no additional documentation was provided at the time of survey. Class III	A 081		
A 082	59A-36.011(4) FAC Training - / (4) / (/). Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on and , including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule. This Statute or Rule is not met as evidenced by: Based on record review and interviews, it was determined that the facility failed to ensure that 3 of 5 sampled staff (Staff B, C, and D) completed	A 082		

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A 082	Continued From page 11 the required ( ) and , ( ) education within 30 days of employment. The findings included: A record review of Staff B's (Medication Assistant) personnel file with a hire date of revealed no documentation of completion of and education within 30 days of employment. A record review of Staff C's (Resident Assistant) personnel file with a hire date of revealed no documentation of completion of and education within 30 days of employment. A record review of Staff D's (Resident Assistant) personnel file with a hire date of revealed no documentation of completion of and education within 30 days of employment. During an interview conducted on at approximately 4:30 PM the Administrator confirmed that all three personnel files lacked documentation of the required training and no additional documentation was produced Class III	A 082		
A 090	59A-36.011(11) FAC Training - (11) TRAINING. (a) Currently employed facility administrators,	A 090		

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A 090	Continued From page 12 managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding . (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure 4 of 5 sampled direct care staff (Staff B, C, D, and J) had received at least 1 hour of training in the facility's policies and procedures regarding ( ). The findings included; A record review of Staff B's (Medication Assistant) personnel file with a hire date of revealed no documentation of completing at least 1 hour of training in the facility's policies and procedures regarding ( ). A record review of Staff C's (Resident Assistant) personnel file with a hire date of revealed no documentation of completing at least 1 hour of training in the facility's policies and procedures regarding ( ). A record review of Staff D's (Resident Assistant) personnel file with a hire date of revealed no documentation of completing at least	A 090		

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A 090	Continued From page 13 1 hour of training in the facility's policies and procedures regarding ( ). A record review of Staff J's (Health Services Director) personnel file with a hire date of revealed no documentation of completing at least 1 hour of training in the facility's policies and procedures regarding ( ). During an interview conducted on at approximately 4:30 PM the Administrator confirmed that the personnel files lacked documentation of the required training on policies and procedures regarding and no additional documentation was provided at the time of survey. Class III	A 090		
A 152	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:	A 152		

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A 152	Continued From page 14 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 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, interview and record review, it was determined that the Facility failed to provide a safe living environment free of safety hazards for all residents that reside at the facility. The findings included: During a tour conducted on between 9:00 AM and 4:00 PM, team of surveyors observed the following physical plant concerns (photo evidence obtained). Elevators Observations on revealed that the two elevators located in building five in the Assisted Living Facility (ALF), had expired inspection	A 152		

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	AL11953207	A. BUILDING: _____ B. WING _____	05/07/2026

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A 152	Continued From page 15 certificates dated . . Second Floor 1) (semiprivate), Resident #14 The resident's room had a very strong odor, and the carpeted area near his bed was wet, heavily soiled, and contained large visible dark brown stains and spills. Common area between rooms (208A and B) The wall behind the resident's recliner had a hole. The carpet near the resident's recliner had large black marks and spills and was visibly soiled. The carpet in the common area near the sliding door had large dark brown stains. 2) (semiprivate), Resident #19 The residents' room revealed visible filth, stains, and soiled carpet. 3) , Resident #15 The residents' room revealed visible filth, stains, and soiled carpet. Fifth Floor 1) Resident #20 The carpet in the common area near her bed and nightstand was heavily soiled, with large visible dark brown stains and spills. The carpeted area in front of her door also had large dark brown stains. Ceiling Tiles: second and third floor The ceiling tiles near the elevator had visible black stains, and the frame surrounding the ceiling tiles showed visible rust-like stains. During an interview on at approximately 2:35 PM, the Administrator was asked to provide the facility's approved annual	A 152		

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A 152	Continued From page 16 elevator certificates of inspection for elevators #9 and #10 (building five). At that time, she confirmed that the facility did not have documentation of approved annual elevator inspection certificates available for review. During an interview on at approximately 5:10 PM, the Administrator acknowledged that the carpet in some of the residents' rooms needed replacement and that the ceiling tiles on the second, third, and fourth floors also needed replacement due to an old leak. The Administrator stated she was aware that both elevators in building five had expired inspection certificates. No additional information was provided. Class III	A 152		

Agency for Health Care Administration

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

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

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ZZ830	Continued From page 2 approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to submit its annual Comprehensive Emergency Management Plan (CEMP) approval request to the local emergency management agency. The findings included: During an interview on at approximately 9:50 AM, the Administrator was asked to provide the facility's current CEMP approval letter or proof of communications and submissions to the Local County Emergency Management Division. Record review of the facility's binder titled CEMP, provided by the Administrator, revealed no documentation of communication or submission to the Local County Emergency Management Division witin the last year. During an interview on at 1:52 PM, the Administrator stated that the facility had gone under new management and that, at this time, there was no documentation available for review. During an interview on at approximately 5:10 PM, the Administrator acknowledged that the facility had not submitted the annual Comprehensive Emergency Management Plan (CEMP). No additional information was provided during the survey. Unclassified	ZZ830		

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