



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2012

Administrator
Highland Terrace
700 Medical Court East
Inverness, FL 34452

Dear Administrator:

Re: Biennial licensure, CCR #2012006929 &
CCR#2012006970

This letter reports the findings of a state licensure survey that was conducted on _____, 2012 by representative(s) of this office.

Enclosed is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after _____, 2012 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call this office at (386) 462-6201.

Sincerely,

Kriste J. Mennella
Field Office Manager

KJM/amw

Enclosure



Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964467	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HIGHLAND TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 700 MEDICAL COURT EAST INVERNESS, FL 34452		
(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)	
A 000	Initial Comments An unannounced Biennial Licensure survey and two Compliance surveys (CCR # 2012006929 & CCR # 2012006970) were conducted on to determine if the facility was in compliance with Chapters 429, Part I & 408, Part II, Florida Statutes and 58A-5 Florida Administrative Code. The facility was not in compliance.	A 000		
A 008 SS=D	58A-5.0181(2) FAC Admissions - Health Assessment (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a face-to-face medical examination completed by a licensed health care provider, as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 calendar days prior to the individual's admission to a facility pursuant to Section 429.26(4), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations; 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living; 3. Any nursing or _____ services required by the individual; 4. Any special diet required by the individual; 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication; 6. Whether the individual has signs or symptoms of a communicable _____ which is likely to be transmitted to other residents or staff; 7. A statement on the day of the examination that, in the opinion of the examining licensed health care provider, the individual's needs can be met in an assisted living facility; and	A 008		

AHCA Form 3020-0001

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

0099

SJPT11

If continuation sheet 1 of 20

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964467	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HIGHLAND TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MEDICAL COURT EAST INVERNESS, FL 34452		
(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)	
A 008	Continued From page 1 8. The date of the examination, and the name, signature, address, phone number, and license number of the examining licensed health care provider. The medical examination may be conducted by a currently licensed health care provider from another state. (b) A medical examination completed after the resident's admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, 2010. The form is hereby incorporated by reference. A faxed copy of the completed form is acceptable. A copy of AHCA Form 1823 may be obtained from the Agency Central Office or its website at www.fdhc.state.fl.us/MCHQ/Long_Term_Care/ < http://www.fdhc.state.fl.us/MCHQ/Long_Term_Care/ > Assisted_living/pdf/AHCA_Form_1823%.pdf. The form must be completed as follows: 1. The resident's licensed health care provider must complete all of the required information in Sections 1, Health Assessment, and 2, Self-Care and General Oversight Assessment. a. Items on the form that may have been omitted by the licensed health care provider during the examination do not necessarily require an additional face-to-face examination for completion. b. The facility may obtain the omitted information either verbally or in writing from the licensed health care provider. c. Omitted information received verbally must be documented in the resident's record, including the name of the licensed health care provider, the name of the facility staff recording the information and the date the information was provided. 2. The facility administrator, or designee, must complete Section 3 of the form, Services Offered		A 008		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964467	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HIGHLAND TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MEDICAL COURT EAST INVERNESS, FL 34452		
(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 008	Continued From page 2 or Arranged by the Facility, or may use electronic documentation, which at a minimum includes the elements in Section 3. This requirement does not apply for residents receiving: a. Extended congregate care (ECC) services in facilities holding an ECC license; b. Services under community living support plans in facilities holding limited mental health licenses; c. Medicaid assistive care services; and d. Medicaid waiver services. (c) Any information required by paragraph (a) that is not contained in the medical examination report conducted prior to the individual's admission to the facility must be obtained by the administrator within 30 days after admission using AHCA Form 1823. (d) Medical examinations of residents placed by the department, by the Department of Children and Family Services, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.426, F.S., and this rule. (f) Any orders for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility issued by the licensed health care provider conducting the medical examination may be attached to the health assessment. A licensed health care provider may attach a _____ order for residents who do not wish _____ to be administered in the case of _____ or _____ (g) A resident placed on a temporary emergency	A 008			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964467	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HIGHLAND TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 700 MEDICAL COURT EAST INVERNESS, FL 34452		
(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 008	Continued From page 3 basis by the Department of Children and Family Services pursuant to Section 415.105 or 415.1051, F.S., shall be exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement shall be entered on the facility's admission and discharge log and counted in the facility census; a facility may not exceed its licensed capacity in order to accept a such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on record review, observation and interview the facility failed to ensure that the AHCA Form 1823 (health assessment) was accurate and complete for 2 (#3, #7) of 2 comprehensive records reviewed. Findings: 1. Review of resident #3 health assessment dated _____ did not contain the facility's address, telephone number, contact person, the type of medication assistance needed, weights, the date assessment conducted, physician's medical license number and address. 2. Review of resident #7 health assessment dated _____ revealed that the medical provider documented the resident as needing her medication administered. Observations and interview with the resident #7 on _____ at 9:00 am revealed that the resident is capable of assisting the staff with her medication.	A 008		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964467	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HIGHLAND TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MEDICAL COURT EAST INVERNESS, FL 34452		
(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 008	Continued From page 4 Class III	A 008			
A 030 SS=D	58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures (6) 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 Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. (b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for 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 address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456. (d) The statewide toll-free telephone number of the Florida _____ Hotline " 1(800)962-2873 " shall be posted in full view in a common area accessible to all residents. (e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964467	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HIGHLAND TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MEDICAL COURT EAST INVERNESS, FL 34452		
(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)	
A 030	Continued From page 5 pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility's policies with respect to such issues, for example, as resident responsibilities, the facility's and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements. (f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law. (g) The facility shall 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 shall not prohibit unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there shall be, at a minimum, an accessible telephone on each floor of each building where residents reside. (h) Pursuant to Section 429.41, F.S., the use of physical _____ shall be limited to half-bed rails, and only upon the written order of the resident's physician, who shall review the order biannually, and the consent of the resident or the resident's representative. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance shall not be considered a physical _____ 429.28 Resident bill of rights.-		A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964467	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HIGHLAND TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 700 MEDICAL COURT EAST INVERNESS, FL 34452	
(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 030	Continued From page 6 (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 achieve the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room _____ or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise	A 030	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964467	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HIGHLAND TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MEDICAL COURT EAST INVERNESS, FL 34452		
(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)	
A 030	Continued From page 7 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) Access to adequate and appropriate health care 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 incapacitated, ... guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. 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 restraint, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.		A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964467	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HIGHLAND TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MEDICAL COURT EAST INVERNESS, FL 34452		
(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)	
A 030	Continued From page 8		A 030		
	This Statute or Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to respond to grievances for 2 of 15 residents (#1 and #9). Findings: 1. On _____ at approximately 1:00 PM during an interview with resident #1's power of attorney (POA) it was stated that the facility failed to respond and resolve a grievance in reference to an over charge on residents #1's bill. According to the POA on _____ he received a bill from the facility for \$6200.00 for resident #1. The POA made request for an itemized bill from the facility breaking down the charges, which he never got. According to the POA he complained to the administrator that resident #1 was being billed for 11 days which she was not in the facility. On _____ during a record review with the Regional Director it was determined that resident #1 was charged for 11 days which she was not in the facility. On _____ an email was sent from the vice president telling the administrator to credit resident #1 for the 11 days. 2. On _____ at 11:27 AM during an interview with resident #9 it was discovered that the facility failed to respond and resolve a grievance regarding missing property. Resident #9 said in the past (unknown date time) she had two watches and a family photo taken from her _____ the facility. She informed the administrator and staff about the missing articles, but noting was				

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964467	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HIGHLAND TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 700 MEDICAL COURT EAST INVERNESS, FL 34452		
(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 030	Continued From page 9 resolved. On _____ at approximately 12:00 PM an interview was conducted with the administrator in reference to resident #9's missing property. The administrator said she was informed of the missing property 4 months ago. It was asked if she resolved and documented the results of the residents grievance, she said "no". Class III	A 030		
A 074	58A-5.019(3)(b) Staffing Standards - Personnel File (BGS) (3) BACKGROUND SCREENING. (b) The results of employee screening conducted by the agency shall be maintained in the employee 's personnel file. This Statute or Rule is not met as evidenced by: Based on personnel record review and interview the facility failed to ensure that 1(#1) of 5 employees personnel file contained documentation of the background screening. Finding: Review of the personnel files revealed that employee #1's personnel file revealed that the employee was hired on _____. Continued review of the file did not reveal any documentation that the employee had received the Level II Background screening. During the interview with the administrator on _____ at 10:00 am, she stated that she was not aware of the missing documentation, she continued to say that the employee was no longer	A 074		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964467	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HIGHLAND TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 700 MEDICAL COURT EAST INVERNESS, FL 34452		
(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)	
A 074	Continued From page 10 working at the facility. Unclassified	A 074		
A 076 SS=D	58A-5.0186 FAC (1) POLICIES AND PROCEDURES. (a) Each assisted living facility (ALF) must have written policies and procedures, which delineate its position with respect to state laws and rules relative to _____. The policies and procedures shall not condition treatment or admission upon whether or not the individual has executed or waived a _____. The ALF must provide the following to each resident, or resident's representative, at the time of admission: 1. A copy of Form SCHS-4-2006, "Health Care Advance Directives - The Patient's Right to Decide," _____ 2006, or with a copy of some other substantially similar document, which incorporates information regarding advance directives included in Chapter 765, F.S. Form SCHS-4-2006 is available from the Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 34, Tallahassee, FL 32308, or the agency's Web site at: http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/HC_Advance_Directives/docs/adv_dir.pdf ; and 2. Written information concerning the ALF's policies regarding _____ and 3. Information about how to obtain DH Form 1896, Florida _____ Form, incorporated by reference in Rule 64J-2.018, F.A.C. (b) There must be documentation in the resident's record indicating whether or not he or she has executed a _____. If a _____ has been	A 076		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964467	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HIGHLAND TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MEDICAL COURT EAST INVERNESS, FL 34452		
(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 076	Continued From page 11 executed, a copy of that document must be made a part of the resident's record. If the ALF does not receive a copy of a resident's executed record, the ALF must document in the resident's record that it has requested a copy. (2) LICENSE REVOCATION. An ALF shall be subject to revocation of its license pursuant to Section 408.815, F.S., if, as a condition of treatment or admission, it requires an individual to execute or waive a (3) PROCEDURES. Pursuant to Section 429.255, F.S., an ALF must honor a properly executed as follows: (a) In the event a resident experiences staff trained in _____ or a licensed health care provider present in the facility, may withhold (b) In the event a resident is receiving hospice services and experiences _____ facility staff must immediately contact the hospice. The hospice procedures shall take precedence over those of the assisted living facility. (4) LIABILITY. Pursuant to Section 429.255, F.S., ALF providers shall not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for following the procedures set forth in subsection (3) of this rule, which involves withholding or withdrawing _____ pursuant to a _____ and rules adopted by the department. This Statute or Rule is not met as evidenced by:		A 076		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964467	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HIGHLAND TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 700 MEDICAL COURT EAST INVERNESS, FL 34452		
(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)	
A 076	Continued From page 12 Based on observations and interview the administrator failed to ensure that the facility had written policies and procedures regarding the Finding: Review of the facility's documentation revealed that they did not contain documentation of their policy and procedures. During the interview with the administrator on at 10:00 am, she stated that the facility did have the policy and procedures, but she was recently hired and did not know where they were filed. Class III	A 076		
A 081 SS=D	58A-5.0191(2) FAC Training - Staff In-Service (2) 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. 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 major incidents.	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964467	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HIGHLAND TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 700 MEDICAL COURT EAST INVERNESS, FL 34452		
(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)	
A 081	Continued From page 13 2. Reporting adverse incidents. 3. 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 (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.	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964467	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HIGHLAND TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MEDICAL COURT EAST INVERNESS, FL 34452		
(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 081	Continued From page 14 This Statute or Rule is not met as evidenced by: Based on interview and record review the facility failed to ensure that 2 (#1,#4) of 5 employees record contained documentation of the required training. Findings: 1. Review of employee #1 personnel record (hired) revealed that the record did not contain the major incident, adverse incident and the facility emergency procedures, resident rights, elopement and nutrition. 2. Review of employee #4 personnel record (hired) revealed that the file did not contain the major incident and adverse incident training, elopement, resident rights, and nutrition. 3. During the interview with the administrator on at 10:00 am, she stated that she was not aware of the missing documentation for employee #4 and employee #1 was no longer working at the facility. Class III		A 081		
A 082 SS=D	58A-5.0191(3) FAC Training - (3) 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		A 082		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964467	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HIGHLAND TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 700 MEDICAL COURT EAST INVERNESS, FL 34452		
(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 082	Continued From page 15 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 interview and record review the facility failed to ensure that 1 (#1) of 5 employees record contained documentation of the required ... training. Findings: 1. Review of employee #1 personnel record (hired ...) revealed that the record did not contain the ... training. During the interview with the administrator on ... 10:00 am, she stated that she was not aware of the missing documentation, she continued to say that the employee was no longer working at the facility. Class III	A 082		
A 090 SS=D	58A-5.0191(11) FAC Training - Do Not Resuscitate ... (11) DO ... (a) Currently employed facility administrators, 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 DNROs ... 60 days after the effective date of this rule. (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	A 090		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964467	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HIGHLAND TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 700 MEDICAL COURT EAST INVERNESS, FL 34452		
(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 090	Continued From page 16 regarding _____ within 30 days after employment. (c) Training shall consist of the information included in Rule 58A-5.0186, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure that 4 (#1,#2,#3,#4) of 4 employees received the training order _____ within 30 days of employment. Finding: Review of the personnel files revealed that employee #1 hired _____ and employee #4 hired _____ had not received the _____ training within 30 days of hire. Continued review of the records revealed that employee #2 hired _____ and employee #3 hired _____ records had not been updated to include the _____ training. During the interview with the administrator on _____ at 2:00 pm, she stated that the facility has been closed for two months and she was in the process of reviewing employee files for completion of their required training. Class III	A 090		
A 167 SS=D	58A-5.025(1) FAC Resident Contracts Resident Contracts. (1) Pursuant to Section 429.24, F.S., prior to or at the time of admission, each resident or legal representative shall execute a contract with the facility which contains the following provisions:	A 167		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964467	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HIGHLAND TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 700 MEDICAL COURT EAST INVERNESS, FL 34452		
(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 167	Continued From page 17 (a) A list of the specific services, supplies and accommodations to be provided by the facility to the resident, including limited nursing and extended congregate care services if the facility is licensed to provide such services. (b) The daily, weekly, or monthly rate. (c) A list of any additional services and charges to be provided that are not included in the daily, weekly, or monthly rates, or a reference to a separate fee schedule which shall be attached to the contract. (d) A provision giving at least 30 days written notice prior to any rate increase. (e) Any rights, duties, or _____ of residents, other than those specified in Section 429.28, F.S. (f) The purpose of any advance payments or deposit payments and the refund policy for such advance or deposit payments. (g) A refund policy which shall conform to Section 429.24(3), F.S. (h) A written bed hold policy and provisions for terminating a bed hold agreement if a facility agrees in writing to reserve a bed for a resident who is admitted to a nursing home, health care facility, or _____ facility. The resident or responsible party shall notify the facility in writing of any change in status that would prevent the resident from returning to the facility. Until such written notice is received, the agreed upon daily, weekly, or monthly rate may be charged by the facility unless the resident's medical condition, such as the resident's being comatose, prevents the resident from giving written notification and the resident does not have a responsible party to act in the resident's behalf. (i) A provision stating whether the organization is affiliated with any religious organization, and, if so, which organization and its relationship to the facility. (j) A provision that, upon determination by the	A 167		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964467	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HIGHLAND TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MEDICAL COURT EAST INVERNESS, FL 34452		
(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)	
A 167	Continued From page 18 administrator or health care provider that the resident needs services beyond those the facility is licensed to provide, the resident or the resident's representative, or agency acting on the resident's behalf, shall be notified in writing that the resident must make arrangements for transfer to a care setting that has services needed by the resident. In the event the resident has no person to represent him, the facility shall refer the resident to the social service agency for placement. If there is disagreement regarding the appropriateness of placement, provisions as outlined in Section 429.26(8), F.S., shall take effect. (k) A provision that residents must be assessed upon admission pursuant to subsection 58A-5.0181(2), F.A.C., and every 3 years thereafter, or after a significant change, pursuant to subsection (4) of that rule. (l) The facility's policies and procedures for self-administration, assistance with self-administration and administration of medications, if applicable, pursuant to Rule 58A-5.0185, F.A.C. This also includes provisions regarding over-the-counter (OTC) products pursuant to subsection (8) of that rule. (m) The facility's policies and procedures related to a properly executed Do Not or Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to have complete resident contracts for 2 of 4 residents (resident #1 and #6). Findings: On 1:00 PM during an interview with the power of attorney (POA) for		A 167		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964467	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HIGHLAND TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MEDICAL COURT EAST INVERNESS, FL 34452		
(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 167	Continued From page 19 resident #1 it was discovered that the resident had been moved from a level II assessment of care to a level III assessment of care without written approval. According to the POA he was informed of this change but it was never approved. On : during a record review of resident #1's contract dated : shows that the resident was under contract for a level I assessment of care. Then a letter from the corporation dated : reassesses resident #1 to an assent level : of care. An invoice dated : reveals that resident #1 was being billed for assesment level III of care. No level three contract was found in the resident's record. On : during a record review of resident #6's contract reveled that exhibit III of the contract which contains the level of service and fees were missing. Class III		A 167		