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
	AL11968250	A. BUILDING: _____ B. WING _____	06/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVINELLE SOUTH ASSISTED LIVING FACILITY INC	1750 NW 41 STREET MIAMI, FL 33142

(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
CZ814 SS=C	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12(2) Care Provider Background Screening Clearinghouse.- (b) Until such time as the [illegible] are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [illegible] submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; [illegible]; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to report a change in status within 10 business days on its employee roster in the background screening clearinghouse system for two out of nine (Staff F and Staff G) sampled staff.	CZ814		

AHCA Form 3020-0001

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

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CZ814	Continued From page 1 Findings Included: On at 10:40 am, the Administrator stated that Staff F and Staff G no longer work at the facility. A review of the facility's background screening database system revealed Staff F was an active employee as of and had no termination date. A review of the facility's background screening database system revealed Staff G was an active employee as of and had no termination date. Unclassified	CZ814		

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A 000	Initial Comments A complaint investigation (#2019006792) was conducted at Calvinelle South Assisted Living Facility, Inc. on , , and concluded on . . . . . Deficiencies were identified at the time of the survey.	A 000		
A 010 SS=G	429.26(1&9) FS; 58A-5.0181(4) FAC Admissions - Continued Residency 429.26 (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination shall be based upon an assessment of the strengths, needs, and preferences of the resident, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (9) A . . . , ill resident who no longer meets the criteria for continued residency may remain in the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a	A 010		

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A 010	Continued From page 1 physician who agrees that the physical needs of the resident are being met. 58A-5.0181 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a [illegible]-to-[illegible] medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 58A-5.0131, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days. (b) A resident requiring care of a [illegible] may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care provider, the resident must be discharged from the facility. (c) A [illegible] ill resident who no longer meets the criteria for continued residency may continue	A 010		

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A 010	Continued From page 2 to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 58A-5.030, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the assisted living facility failed to ensure the continued appropriateness of one out of four (Resident # 2) sampled residents based after a	A 010		

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A 010	Continued From page 3 significant change. Resident # 2 verbally threatened a fellow resident and physically [illegible] a staff person. Findings included: During a complaint inspection regarding another matter, a review of Resident #2's record showed Resident # 2's record showed an acceptance letter to a felony jail diversion program for battery on an elderly person from the Eleventh Judicial Circuit Criminal Mental Health Project. A review of the Adverse Incident Reporting System (AIRS) revealed a report stating Resident # 2 had physically assaulted Staff F on [illegible], which resulted in Resident # 2 being [illegible] and Staff F being transported to a local hospital. Further review of Resident #2's record showed he was admitted to the assisted living facility on [illegible] and there was no documentation of the incident that occurred on [illegible]. A review of Resident #2's health assessment dated [illegible] showed diagnoses of [illegible], and [illegible]. The resident needed [illegible] precautions, and was independent in activities of daily living, but needed assistance with self-administration of medications. On [illegible] at 3:09 pm, when asked by telephone about the assault, the Administrator became upset and stated that it would be best to speak with the facility manager regarding the incident. When asked who the facility manager was, the Administrator hung up. A review of the Background Screening Clearinghouse database and facility records showed that no manager was listed. At 3:21 pm the Administrator called [illegible], apologized for hanging up, and stated that there was no manager. He further stated that Staff F	A 010		

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A 010	Continued From page 4	A 010		

was assaulted, and no longer worked at the facility, but did work at another facility owned by the same group. He stated that Staff F was taken to the hospital, but that no other interventions were made after the assault. The Administrator stated that the courts were involved and they were afraid of Resident #2 getting worse if he moved. He stated that he didn't know why Staff F was assaulted.

On [redacted] at 4:32 PM, Staff F stated "On [redacted], I heard Resident #2 yelling and threatening another resident in the morning. I asked him to stop, but he was very agitated and in a rage. I was in the kitchen when Resident # 2 approached me and told me I was not his father and put his [redacted] over my [redacted] and I [redacted]". Staff F then explained that he was so badly hurt, he had to be taken to the hospital for medical treatment.

On [redacted] at 4:06 PM, Staff C stated that she had been in contact with Resident #2's program because "he's become increasingly more irritable and his sleeping patterns were off. His medications were reconciled, but there was no explanation on why he's become more irritable." She further stated that the incident happened when someone asked Resident # 2 for a cigarette and Resident # 2 responded rudely to a resident and the staff intervened. Staff C stated "His sister couldn't even explain why".

A review of progress notes from Resident # 2's day program/medical provider revealed a letter dated [redacted] from the Chief Medical Officer (CMO) stating that "it is no longer safe" for Resident # 2 to continue at the program and that the resident "needs a higher level of [redacted] intervention". Further review revealed a note from

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A 010	Continued From page 5 his social worker stating Resident # 2 needed to be "in a more appropriate residential facility to receive the services he needed". Additionally, a progress note dated showed that Resident # 2's sister had called his social worker to report he was more irritable. His notes also stated that Staff C reported that Resident # 2 "appeared to be decompensating as evidenced by being increasingly irritated, disheveled, and unkempt". Staff C also added that staff was afraid that the resident may become physically aggressive as he did in the past. On at 11:17 am during a telephone interview, the social worker, the site director and the Quality Manager at Resident #2's health care provider site stated that they were aware of his behaviors and that the determination was made that the member required alternative care, needed increased supervision at a higher level of care, and more , , . . . services. The site director further stated that the resident was not currently allowed to come for services at the program site, due to staff concerns for his safety and the safety of the other participants and the staff. He stated that their decision was based on Resident #1's need for , , . . . services and that the magnitude of the aggressiveness did not match their level of services. On . . . . at 12:04 pm during a telephone interview, Staff G stated that she was present at the time of the assault on Staff F. She stated that she heard Resident #3 arguing with another resident, stating "I want to punch him." Staff F said to Resident #2 'You cannot do or say that.' Two seconds later, Resident #3 was punching Staff F, and she called the police. Class II	A 010		

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A 030 SS=D	58A-5.0182(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 58A-5.0182 (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 Program must 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 must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 58A-5.0181, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:	A 030		

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A 030	Continued From page 7 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 universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical .	A 030		

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A 030	Continued From page 8 429.28 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 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	A 030		

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A 030	Continued From page 9	A 030		

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 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

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A 030	Continued From page 10 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 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(1)(a), FS	A 030		

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A 030	Continued From page 11 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 record review and interview, the facility failed to honor resident's right by not providing one out of 13 (Resident # 1) sampled residents a 45-day notice of discharge. The facility also failed to provide meals upon request to one out of 13 (Resident # 10) sampled residents. Findings included: 1) A review of the facility's admission and discharge log revealed Resident # was discharged from the facility on . A review of Resident # 1's records showed no documentation of a 45-day notice given to the resident or her legal guardian. Further review of Resident # 1's records also did not show any	A 030		

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	AL11968250	A. BUILDING: _____ B. WING _____	06/04/2019

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A 030	Continued From page 12 progress notes stating that Resident # 1 was being discharged to a different facility. On at 3:21 pm, when requested to provide documentation of Resident # 1's 45-day notice of discharge, the Administrator stated that he is not at the office at the moment and will fax it tomorrow. No documentation was received. On at 3:57 pm, Staff C stated that the facility held Resident # 1's bed and suspended her payment for the time Resident # 1 was missing. The facility then gave up Resident # 1's bed after a month and after receiving approval from Resident # 1's guardian and insurance. Staff C then admitted that a 45-day notice of discharge was never given. On . . . . . at 10:56 am, Staff A stated "Sometimes we move residents between the three locations to best fit their needs. Sometimes the residents won't get along with other residents in the facility and would move to another location where they will get along". 2) On at 7:08 am and 7:20 am, Resident # 10 stated that she was hungry and wanted breakfast to Staff B. On at 7:22 am, Staff B stated that Resident # 10 had to wait until the next shift arrived. Staff B stated that since he worked the overnight shift he never cooked, because the day shift are the ones that do it. Class III	A 030		
A 032 SS=G	58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(i) Resident Care - Elopement Standards	A 032		

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A 032	Continued From page 13 58A-5.0182 (8) 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 58A-5.0181(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 58A-5.0191(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 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	A 032		

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A 032	Continued From page 14 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 sections 429.41(1)(a)3. and 429.41(1)(l), F.S. 429.41(1)(a)3 & 3(l),FS 3. Resident elopement requirements.-Facilities are required to conduct a minimum of two resident elopement prevention and response drills per year. All administrators and direct care staff must participate in the drills which shall include a review of procedures to address resident elopement. Facilities must document the implementation of the drills and ensure that the drills are conducted in a manner consistent with the facility's resident elopement policies and procedures. (l) The establishment of specific policies and procedures on resident elopement. Facilities shall conduct a minimum of two resident elopement drills each year. All administrators and direct care	A 032		

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A 032	Continued From page 15	A 032		

staff shall participate in the drills. Facilities shall document the drills.

This Statute or Rule is not met as evidenced by:
Based on record review and interview, the facility failed to coordinate care for one out of 13 (Resident # 1) sampled residents. The facility did not provide any documentation of an intervention plan or communication about Resident # 1's elopement behaviors to her day program after Resident # 1 attempted to jump the facility's fence. Resident #1 eloped from the day program and was found on the street and was hospitalized more than two months later. The facility also failed to follow it's policies and procedures regarding elopement. The facility also failed to ensure that three out of eight (Staff A, D, and E) sampled staff members understood the facility's elopement policies and procedures. Furthermore, the facility failed to have a photo identification of at-risk residents for elopement for two out of 13 (Resident # 1 and # 9) sampled residents.

Findings included:

1) A review of Resident # 1's most current health assessment dated revealed a diagnosis of , , , and . Resident #1 was identified as an elopement risk.

Additional review of Resident #1's records revealed a progress note dated stating "Resident #1 is becoming increasingly more agitated and combative refusing medication, not sleeping and attempting to leave ALF in middle of night". A review of Resident # 1's hospital records revealed resident was admitted to a local hospital on . The emergency care notes stated "The patient presents with ,

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A 032	Continued From page 16	A 032		

problem. . . , female presents to emergency department via Emergency Medical Services (. .) due to noncompliance and . . . . Per ALF records, patient has and refuses to take medication. On arrival to Emergency Department, patient stated "they took my baby, the bots and shot it up me."

Review of Resident #1's record showed no documentation that the resident's day program was informed of the . . . . . elopement attempt. Further review of Resident #1's records revealed another progress note dated . . . . . stating "Resident #1 was picked up along with 2 other residents in the morning by their program. At 2 pm when the other 2 residents returned, Resident #1 was not on the bus". # 1 from eloping again.

A review of Resident # 1's hospital records revealed resident arrived to a local hospital on . . . . . under a . . . . . after she was found . with all over her . The resident was very disorganized, described by the hospital record as "grossly , , , bizarre, internally preoccupied self-agitated, , mal odorous, at high risk of harming self/others and at very high risk of self-neglect."

A review of the facility's policies and procedures for elopement revealed the definition of elopement and a procedure in reporting elopement. The policy stated that elopement was described as leaving the premises without permission or notice. It further stated that at a minimum, the facility would ensure that residents at risk for elopement had a photo identification with the resident's name and the facility name, address and phone number. The policy stated that if a client left, staff should notify law enforcement immediately. The policy stated,

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A 032	Continued From page 17 regarding notification, that the administrator would notify law enforcement , family/guardian, health care surrogate, treatment personnel, and case manager of elopement. On at 3:40 pm, an interview with Resident #1's legal guardian confirmed that Resident #1 had eloped from her day program on and was found two months later on . in a local hospital. A review of Resident #1's file from the day program showed no documentation of contacts with the facility indicating that the resident had tried to leave the facility without permission at any time. 2) A review of the facility's policies and procedures for elopement revealed the definition of Elopement and a procedure in reporting elopement. The policy stated that elopement was described as leaving the premises without permission or notice. It further stated that at a minimum, the facility would ensure that residents at risk for elopement had a photo identification with the resident's name and the facility name, address and phone number. The policy stated that if a client left, staff should notify law enforcement immediately. The policy stated, regarding notification, that the administrator would notify law enforcement , family/guardian, health care surrogate, treatment personnel, and case manager of elopement. On at 10:10 AM, when asked Staff E what to do in the case a resident eloped, she stated "what does elopement mean?". When explained what elopement meant, Staff E stated "We wait for 24 hours before calling the police and notify management. If someone is missing	A 032		

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A 032	Continued From page 18 and they don't sign out from the notebook we have, I'll call management first and let them figure it out". Staff E also stated that none of the residents have tried to elope or have eloped. On at 10:16 am, when asked what she would do if a resident had eloped, Staff D stated that she would contact the administrator and wait on instructions. 3) A review of Resident # 9's records revealed she was identified as an elopement risk. On at 9:11 am, an interview with Resident # 9 revealed that she did not know the address to the facility. Resident # 9 stated that she knew she had a photo in her file from her program; however, she did not carry it when she went out of the facility. Class II	A 032		
A 052 SS=D	429.256( ); 58A-5.0185 (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, including an . . syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer, from where it is stored, and bringing it to the resident. (b) In the presence of the resident, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container. (c) Placing an oral dosage in the resident ' s . .	A 052		

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A 052	Continued From page 19 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 . (h) Using a ..... to perform ....-..... level checks. (i) Assisting with putting on and taking off stockings. (j) Assisting with applying and removing an ..... but not with titrating the prescribed ..... settings. (k) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device. (l) Assisting with measuring vital signs. (m) Assisting with , bags. (4) Assistance with self-administration 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.	A 052		

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A 052	Continued From page 20 (d) Administration of preparations. (e) Irrigations or debriding agents used in the treatment of a skin condition. (f) , , or preparations. (g) 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 at the request of a competent resident. (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. 58A-5.0185 (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 58A-5.0191, 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, in the presence of the resident, reading the medication label aloud and verbally prompting a resident 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	A 052		

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A 052	Continued From page 21 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. 1. As used in section 429.256(4)(g), F.S., the term "competent resident" means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication. 2. As used in section 429.256(4)(h), F.S., the	A 052		

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A 052	Continued From page 22 terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (g) 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, interview, and record review, the facility failed to follow the procedures outlined by the state while assisting one out of 13 (Resident # 4) sampled residents with self-administration of medication. Findings included: On at 7:27 am, observed Staff B assist Resident # 4 with self-administration of medication. Staff B placed the medication from the pack into a little cup and handed it to Resident # 4. Staff B did not identify what medication Resident # 4 was taking, then observed Resident # 4 take the medication, and then signed the Medication Observation Record (MOR). A review of Resident # 4's MOR revealed the medications scheduled for 9 am were Desylate 10 mg Tablet, Buprinon XL 150 mg Tablet, 5 mg Tablet, 12.5 mg Capsule, 10 mg Tablet, D3 2,000 unit Softgel, 1,000 Mg Tablet, and 25 mg Tablet. On at 7:30 am, Staff B stated that he usually does not provide the residents their medication because the morning shift usually does it.	A 052		

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A 052	Continued From page 23 Class III	A 052		
A 054 SS=D	58A-5.0185(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:	A 054		

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A 054	Continued From page 24 Based on record review and interview, the facility failed to maintain an accurate daily Medication Observation Record (MOR) for two out of 13 sampled residents (Residents # 6 and # 9). The facility also failed to provide doctor's orders for three out of 13 (Residents # 6, # 7, and #9) sampled residents. Findings included: A review of Resident # 6's MOR revealed a handwritten MOR which did not have any documentation of any known [illegible] and the name of the resident's healthcare provider along with their phone number. Further review of Resident # 6's records showed no documentation of any prescriptions from a healthcare provider. A review of Resident #7's records did not show any documentation of any prescriptions from a healthcare provider. A review of Resident # 9's MOR revealed a handwritten MOR which did not have any documentation of any known [illegible] and the name of the resident's healthcare provider along with their phone number. Further review of Resident # 9's records showed no documentation of any prescriptions from a healthcare provider. Class III	A 054		
A 056 SS=D	58A-5.0185(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they	A 056		

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A 056	Continued From page 25 are properly labeled and dispensed in accordance with chapters 465 and 499, F.S., and rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , . , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the	A 056		

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A 056	Continued From page 26 medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to section 465.0276(5), F.S., and rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order.	A 056		

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A 056	Continued From page 27 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation of any change in directions for use of a medication for seven out of ten (Residents # 2 - 5, # 8, # 10, and # 11) sampled residents. Findings included: A review of Resident # 2's Medication Observation Record (MOR) revealed he was prescribed to take 20mg Tablet, 500 mg Tablet, Quatrain 50 mg Tablet, Freeze-It Relief Roll-On and 50 mg Tablet scheduled at 9 PM. He was also prescribed to take 81 mg Tablet, 500 mg Capsule, Succ ER 25 mg Tablet, 20mg Tablet, D3 1,000 IU Tablet, 500 mg Tablet, Quatrain 50 mg Tablet, and Freeze-It Relief Roll-On at 9 am. Further review of Resident # 2's MOR revealed the scheduled times were crossed out and changed to 7 am and 7 pm. There was no documentation or doctor's order stating that the medication times had to be changed. A review of Resident # 3's MOR revealed she was prescribed to take 81 mg Tablet, 100 mg Softgel, 40 mg Tablet, D3 2,000 unit Tablet, MES 20mg Tablet, 10 mg Tablet, 850 mg Tablet, 12% Cream at 9 am. She was also prescribed to take MES 20mg Tablet, 10 mg Tablet, 850 mg Tablet, and 100 mg Tablet at 9 pm. Further review of Resident # 3's MOR revealed the scheduled	A 056		

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A 056	Continued From page 28 times were crossed out and changed to 7 am and 7 pm. There was no documentation or doctor's order stating that the medication times had to be changed. A review of Resident # 4's MOR revealed she was prescribed to take , Desylate 10 mg Tablet, Buprinon XL 150 mg Tablet, , 5 mg Tablet, , 12.5 mg Capsule, , 10 mg Tablet, D3 2,000 unit softgel, 1,000 Mg Tablet, and Tratrate 25 mg Tablet 9 am. She was also prescribed to take 1,000 Mg Tablet at 7 pm, and Tratrate 25 mg Tablet, Hydroxizine Pam 50 mg Capsule and 20mg Tablet at 9 pm. Further review of Resident # 4's MOR revealed the scheduled times were crossed out and changed to 7 am, 5 pm, and 7 pm. There was no documentation or doctor's order stating that the medication times had to be changed. A review of Resident # 5's MOR revealed she was prescribed to take Denztropine MES 20mg Tablet, 10 gm/15 ml Solution, B-1 100 mg Tablet, D3 2,000 unit Softgel, , 1 mg Tablet, and , 10 mg Tablet at 9 am. Further review of Resident # 5's MOR revealed the scheduled times were crossed out and changed to 7 am. There was no documentation or doctor's order stating that the medication times had to be changed. A review of Resident # 8's MOR revealed she was prescribed to take , 10 mg, , Low 81 mg , , 20mg, Dok 100 mg, and , 20mg at 8 am. She was also prescribed to take , 5 mg, Rosuvastatin 10 mg, and 8.5mg at 8pm. Further review of Resident # 8's MOR revealed the scheduled times were crossed out and changed to 7am and 7pm. There was no	A 056		

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A 056	Continued From page 29 documentation or doctor's order stating that the medication times had to be changed. A review of Resident # 10's MOR revealed she was prescribed to take , 81mg Tablet, 100mg Softgel, , 30mg Tablet, D3 2,000 unit Tablet, , MES 0.5mg Tablet, , 0.5mg Tablet, and , 1mg Tablet at 9am. She was also prescribed to take , MES 0.5mg Tablet, , 0.5mg Tablet, and , 15mg Capsule at 9pm. Further review of Resident #10's MOR revealed the scheduled times were crossed out and changed to 7am and 7pm. There was no documentation or doctor's order stating that the medication times had to be changed. A review of Resident # 11's MOR revealed he was prescribed , 81mg Tablet, 100mg Softgel, , 2.5mg Tablet, 500mg Tablet, and 150mg Tablet at 9am. He was also prescribed to take 500mg Tablet, 150mg Tablet, Qutetiapine ER 400mg Tablet, 20mg Tablet, and 0.4mg Capsule at 7pm. Further review of Resident #11's MOR revealed the scheduled times were crossed out and changed to 7am and 7pm. There was no documentation or doctor's order stating that the medication times had to be changed. On at 10:28am, Staff E stated that they changed the times according to when the residents leave to the program, the time they usually wake up, and when they go to bed. Staff D stated that the pharmacy did not change the medication times.	A 056		

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A 056	Continued From page 30 Class III	A 056		
A 079 SS=D	58A-5.019(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 212 16- 25 253 26-35 294 36-45 335 46-55 375 56- 65 416 66-75 457 76-85 498 86-95 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 58A-5.024(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there	A 079		

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A 079	Continued From page 31 must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and , , ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 58A-5.0191(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least , must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in	A 079		

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A 079	Continued From page 32	A 079		

meeting the minimum staffing hours. Vacant positions or absent staff may not be counted.
(b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 58A-5.0182, F.A.C.
(c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives.
(d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 58A-5.0182, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met.
1. When additional staff is required above the

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A 079	Continued From page 33	A 079		

minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs.
2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency.
(e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios.
(f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 58A-5.029, 58A-5.030 or 58A-5.031, F.A.C., respectively.

This Statute or Rule is not met as evidenced by:
Based on interview and record review, the facility failed to maintain an accurate staffing schedule.

Findings included:

On . . . . at 7:05am, observed only one staff member working in the facility.

A review of the facility's schedule revealed two staff members were scheduled to work from 7pm - 7am on .

On at 7:08am, Staff B stated "I have been

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A 079	Continued From page 34 working since 7pm last night. The other employee called out and the next employee that is supposed to start at 7am is running late". Class III	A 079		
A 081 SS=D	58A-5.0191( ) FAC Training - Staff In-Service (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 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	A 081		

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A 081	Continued From page 35	A 081		

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 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.

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A 081	Continued From page 36 (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 observation, interview, and record review, the facility failed to ensure one out of eight (Staff B) sampled staff completed a preservice orientation of at least 2 hours prior to interacting with residents. Findings included: On . . . . . at 7:27am, observed Staff B assist Resident # 4 with self-administration of medication. A review of Staff B's records revealed a hire date of and there was no documentation or certificate of completion of a preservice orientation. On at 11:35am, the Administrator acknowledged that Staff B had to complete a pre-service orientation. Class III	A 081		
A 093 SS=D	58A-5.020(2) FAC Food Service - Dietary Standards	A 093		

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A 093	Continued From page 37 (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are incorporated by reference and available for review at: http://iom.edu/Activities/Nutrition/SummaryDRIs/~/media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%2014.pdf. 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	A 093		

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	AL11968250	A. BUILDING: _____ B. WING _____	06/04/2019

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A 093	Continued From page 38 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 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	A 093		

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A 093	Continued From page 39 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 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 and record review, the facility failed to ensure their daily menu was followed with the appropriate documentation of any substitutions served during breakfast. Findings included: On at 8:05AM, breakfast observation showed the residents were served ¾ cup of dry cereal with 8 oz. of milk, a slice of bread (toasted) with 1 teaspoon of margarine, and 8 oz. of coffee.	A 093		

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A 093	Continued From page 40 A review of the facility's menu revealed the scheduled breakfast consisted of 4 oz Assorted juice, ¾ cup of dry cereal or ½ cup of hot cereal, 1 slice of bread, 1 teaspoon of margarine, and 8 oz of milk. No substitution remarks were made to the menu. On at 8:12am, Staff E stated 'The residents like drinking coffee so I always give them a cup of coffee.' Class III	A 093		
A 152 SS=D	58A-5.023(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;	A 152		

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A 152	Continued From page 41 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 and interview, the facility failed to provide a clean and safe environment for all residents. The facility also failed to ensure all existing architectural, mechanical, electrical and structural systems, and appurtenances were maintained in good working order. Findings included: On during the tour of the facility at 6:30 am, observed: A torn and damaged bed comforter in # that had the comforter's filling hanging on the side of the bed. A bed without any linen sheets or comforter in # . Several missing window blinds in # , # 4, # 5, and # 6. A punched hole in the door and a cracked	A 152		

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A 152	Continued From page 42 floorboard in . . # 's. An unpainted cement patch located in the hallway's ceiling and in # . A missing tile located in one of the bathroom's shower and cracked painting on the bathroom walls. Two unhinged closet doors and dirty pillows with a foul odor in . . # and . . # . . One of the bathrooms had uneven paint on the side door and a dirty rug. Two , light switches. One located in the bottom of a stairwell and one light switch located in # . Seven large, cockroaches under the kitchen sink, one large . . . . . cockroach under a cabinet, and a live large, flying cockroach on the refrigerator's door. On . . . . . at 11:35am, the Administrator acknowledged he needed to make some improvements to the facility. Class III	A 152		
A 160 SS=D	58A-5.024(1) FAC Records - Facility The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this	A 160		

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A 160	Continued From page 43 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 [illegible]; 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 58A-5.025, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of [illegible]. (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 58A-5.026, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in Rule 58A-5.021, F.A.C.; (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 58A-5.021, F.A.C.	A 160		

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A 160	Continued From page 44 (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 58A-5.0181, 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 58A-5.0182, F.A.C. (j) All food service records required in Rule 58A-5.020, 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 429.41, 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) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules	A 160		

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A 160	Continued From page 45 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to have an updated admission and discharge log. Three out of 13 (Resident # 1, # 12, and # 13) sampled residents were not listed accurately. Findings included: A review of the facility's admission and discharge log revealed Resident # 1's admission date of [redacted] and a discharge date of [redacted]. Further review of the admission and discharge log revealed Resident # 12's admission date of [redacted] and a discharge date of [redacted]. In addition, Resident # 13's was admitted on [redacted] and had a discharge date of [redacted]. On [redacted] at 10:56am, the Administrator stated that the dates must have been written in error and will fix them. Class III	A 160		
A 162 SS=D	58A-5.024(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. [redacted]; 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	A 162		

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A 162	Continued From page 46 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 health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in Rule 58A-5.0181, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider ' s order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 58A-5.020, F.A.C., if applicable. (e) The resident care record described in paragraph 58A-5.0182(1)(e), 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. (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 58A-5.0181, 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 58A-5.0185, F.A.C. (i) A copy of the resident's contract with the	A 162		

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A 162	Continued From page 47	A 162		

facility, including any addendums to the contract as described in Rule 58A-5.025, F.A.C.
(j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S.
(k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property 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 58A-5.0181, 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

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A 162	Continued From page 48 nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement; 2. The resident demographic data required in this paragraph; 3. The health assessment described in Rule 58A-5.0181, F.A.C.; 4. The resident's contract described in Rule 58A-5.025, F.A.C.; and 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon 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 58A-5.029, 58A-5.030 and 58A-5.031, 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 accurate documents in resident's records for two out of 13 (Resident # 2 and # 7) sampled residents. Findings included: A review of Resident # 2's records revealed a signed Consent for Release of Information and Patient Right Responsibilities from a different	A 162		

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A 162	Continued From page 49 facility. A review of Resident # 7's records revealed a signed Resident Agreement contract from a different facility. On . . . . . at 11:35am, the Administrator acknowledged the inaccurate documents and explained that the documents come from their previous facilities they used to live in. Class III	A 162		