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
	AL11968849	A. BUILDING: _____ B. WING _____	C 05/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF LIGHT SENIOR LIVING III	2306 WOODLAWN CIRCLE MELBOURNE, FL 32934

(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 interviews the facility failed to ensure one of four staff (Staff D) was listed on the facility background-screening roster. Findings include:	CZ814		

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CZ814	Continued From page 1 On [redacted] at 10:00 AM, in an interview with Staff D, Staff D stated she works at the facility to help with, "Administrative stuff." When asked, Staff D stated she has direct involvement in the care of the residents. On [redacted] in a record review of the facility background-screening roster, the roster did not provide documentation of Staff D being employed at the facility. On [redacted] at 12:20 PM, in an interview with the administrator, the administrator stated Staff D is in the process of becoming CORE trained. The administrator stated Staff D is listed on the background-screen of one of the other properties. The administrator stated she was unaware she needed to add her to each facility background-screening roster. Unclassified	CZ814		
CZ816 SS=C	408.809(2)(a-c); 59A-35.090(2)(d)-(3) Background Screening-Compliance Attestation 408.809 (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's [redacted] to the Federal Bureau of Investigation for a national criminal history record check unless the person's [redacted] are enrolled in the Federal Bureau of Investigation's national retained print [redacted] notification program. If the [redacted] of	CZ816		

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CZ816	Continued From page 2 such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit [illegible] electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the [illegible] to the Federal Bureau of Investigation for a national criminal history record check. The [illegible] shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person [illegible]. Until a specified agency is fully implemented in the clearinghouse created under s. 435.12, the agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the agency, the Department of Health, the Department of Elderly Affairs, the Agency for Persons with [illegible], the Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that: (a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section; (b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and (c) Such proof is accompanied, under penalty of	CZ816		

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CZ816	Continued From page 3 perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency. 59A-35.090(2) Processing Screening Requests, Required Documents and Fees. (d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, , herein incorporated by reference, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-09106, and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Regulations_Forms.shtml. This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if for any disqualifying offense. (e) An administrator or chief financial officer must be screened and qualified prior to to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the report and court disposition information. If the letter is returned	CZ816		

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CZ816	Continued From page 4 unclaimed, a copy of the letter will be sent by regular mail. Pursuant to section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with section 435.06(3), F.S. (c) The eligibility results of employee screening and the signed Attestation referenced in subsection 59A-35.090(2), F.A.C., must be in the employee's personnel file, maintained by the provider. This Statute or Rule is not met as evidenced by: Based on record review and interviews the facility failed to provide documentation of three of three staff (Staff A, B and C) having completed the background screening attestation. Findings include: On in a record review of Staff A's employee file, Staff A's file documented a hire date of . Staff A's file failed to provide documentation Staff A had completed the required background-screening attestation. On in a record review of Staff B's employee file, Staff B's file documented a hire date of . Staff B's file failed to provide documentation of Staff B having completed the required background-screening attestation. On in a record review of Staff C's employee file, Staff C's file documented a hire date of . Staff C's file failed to provide documentation of Staff C had completed the required background-screening attestation. On at 12:20 PM, in an interview with the administrator, the administrator stated the	CZ816		

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CZ816	Continued From page 5 files she provided for employee records are complete and she does not understand why the records are not in the files. Unclassified	CZ816		
A 000	Initial Comments An unannounced complaint investigation (2019004689) was conducted at the House of Light III Assisted Living Facility, 2306 Woodlawn Circle, Melbourne, Florida, on , and 24, 2019. Deficient practice was found at the time of the investigation.	A 000		
A 025 SS=D	429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 58A-5.0182 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following:	A 025		

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A 025	Continued From page 6 (a) Monitoring of the quantity and quality of resident diets in accordance with rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews the facility placed one of six residents (Resident #6) at-risk by failing to maintain a written record of any significant changes. Findings include: On in a record review of the AHCA Adverse Incident Reporting System (AIRS), the AIRS system documented Resident #6 eloped from the facility during a holiday party on . The AIRS report stated that Resident #6 left through an unlocked gate. On in a record review of local law	A 025		

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A 025	Continued From page 7 enforcement reports, the report documented that law enforcement was called to investigate an elopement by Resident #6 on ..... at 6:15 PM. On at 10:18 AM, in an interview with Staff B, Staff B stated she was involved in the elopement at the holiday party on by Resident #6. Staff B stated Resident #6 was able to leave through an open garage door. On in a record review of Resident #6's file, the file did not contain any documentation related to the elopement on . The file did not have any notes documenting contact with family members or Resident #6's primary care physician. On ..... at 12:30 PM, in an interview with the administrator, the administrator stated she had contacted Resident #6's family but did not keep a written record. On at 1:30 PM, in an interview with Resident #6's family, the family stated they were contacted but told Resident #6 had just gotten outside. The family stated they were never told Resident #6 was an elopement risk or had eloped from the property. Class III	A 025		
A 032 SS=D	58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(i) Resident Care - Elopement Standards 58A-5.0182 (8) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or	A 032		

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A 032	Continued From page 8 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 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:	A 032		

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A 032	Continued From page 9 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 staff shall participate in the drills. Facilities shall document the drills. This Statute or Rule is not met as evidenced by: Based on record reviews, observations and interviews the facility placed two of six residents	A 032		

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A 032	Continued From page 10 (Residents #5 and #6) at-risk by failing to follow facility-operating procedures regarding elopements. Findings include: On [redacted] in a record review of the facility operating procedure regarding elopements, the procedure outlines the following for all residents documented as an elopement risk: 1- photo kept in the resident file and 2- wristband worn by elopement risk residents, which notes, resident name, facility telephone number and facility address. On [redacted] in a record review of Resident #5's file, the files 1823 AHCA health assessment documents Resident #5 as an elopement risk. The 1823 AHCA health assessment, signed on [redacted], documents Resident #5 with [redacted] and [redacted]. On [redacted] at 12:20 PM, in an observation of Resident #5, Resident #5 was observed not wearing the facility required wristband or other form of identification. On [redacted] at 12:20 PM, in an interview with the administrator, the administrator acted [redacted] when the surveyor asked about a safety plan for Resident #5. When it was stated the Resident #5's 1823 AHCA health assessment documented her as an elopement risk, the administrator stated, "Why, she hasn't eloped." On [redacted] in a record review of the Agency Adverse Incident Reporting System (AIRS), the system documented Resident #6 elopement from the facility during a holiday party on [redacted] at 6:15 PM.	A 032		

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A 032	Continued From page 11 On in a record review of Resident #6's file, the file documents Resident #6's 1823 AHCA health assessment was signed on . The 1823 AHCA health assessment documents Resident #6 is an elopement risk and suffers from and . On at 11:35 AM, in an observation of Resident #6, Resident #6 was observed not to be wearing the facility required wristband or any other identification. On at 10:18 AM, in an interview with Staff B, Staff B stated she does not know anything about elopement drills and has not had any training regarding elopements. On at 11:50 AM, in an interview with Staff G, Staff G stated she has not been trained in elopement procedures. Class III	A 032		
A 078 SS=D	58A-5.019(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership.	A 078		

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A 078	Continued From page 12 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 58A-5.0191, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing	A 078		

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A 078	Continued From page 13 agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff . . . . . by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure the safety of residents by providing the required documentation of two of three staff (Staff A and C) being free of communicable . The facility failed to ensure three of three staff (Staff A, B and C) had submitted negative examinations. Findings include: On in a record review of Staff A's employee file, Staff A's file documented a hire date of . Staff A's file failed to provide documentation Staff A had completed testing for communicable or a negative examination. On . . . . in a record review of Staff B's employee file, Staff B's file documented a hire date of . . . . . Staff B's file failed to provide documentation Staff B having completed a negative . . . . . examination. On . . . . . in a record review of Staff C's employee file, Staff C's file documented a hire date of . . Staff C's file failed to provide documentation Staff C had completed testing for	A 078		

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	AL11968849	A. BUILDING: _____ B. WING _____	C 05/24/2019

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A 078	Continued From page 14 communicable . . . . . or a negative . . . . . examination. On at 12:20 PM, in an interview with the administrator, the administrator stated the files she provided for employee records are complete and she does not understand why the records are not in the files. Class III	A 078		
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	A 081		

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A 081	Continued From page 15 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 [illegible] control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its [illegible] control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to [illegible] borne [illegible], 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 [illegible], neglect, and [illegible]. The facility must use its [illegible] 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.	A 081		

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A 081	Continued From page 16 (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure three of three staff (Staff A, B and C) had proper documentation of completed the required pre-service orientation prior to interacting with residents. Findings include: On in a record review of Staff A's employee file, Staff A's file documented a hire date of . Staff A's file failed to provide documentation Staff A had completed the required pre-service orientation prior to interacting with residents. On in a record review of Staff B's employee file, Staff B's file documented a hire date of . Staff B's file failed to provide documentation of Staff B having completed the required pre-service orientation prior to interacting with residents. On in a record review of Staff C's	A 081		

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A 081	Continued From page 17 employee file, Staff C's file documented a hire date of . Staff C's file failed to provide documentation of Staff C had completed the required pre-service orientation prior to interacting with residents. On in a record review of the employee work schedule, the work schedule documented Staff A, B and C all had assigned work shifts for the week of , to 25, 2019. On at 12:20 PM, in an interview with the administrator, the administrator stated the files she provided for employee records are complete and she does not understand why the records are not in the files. Class III	A 081		
A 083 SS=D	58A-5.0191(5) FAC Training - First Aid and (5) FIRST AID AND ( ). 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 that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently	A 083		

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A 083	Continued From page 18 certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure one of three staff (Staff A) had completed the required training for First Aid and [illegible] ( ) prior to working without other staff in the building. Findings include: On in a record review of Staff A's employee file, the file documented Staff A's date of hire as . The file did not contain documentation Staff A having completed First Aid or training. On in a record review of the facility work schedule for the week of to 25, 2019, the schedule documented Staff A worked a 24-hour shift alone on and On at 11:45 AM, in an interview with Staff A, Staff A denied working any shifts alone. When asked who worked with her, Staff A was unable to provide the information. On at 12:20 PM, in an interview with the administrator, the administrator stated despite what the work schedule documentations no one works alone. When asked who works with Staff A, the administrator was unable to provide a name. Class III	A 083		
A 090 SS=D	58A-5.0191(11) FAC Training - (11)	A 090		

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A 090	Continued From page 19 TRAINING. (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 . (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding . within 30 days after employment. (c) Training shall consist of the information included in rule 58A-5.0186, F.A.C. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure two of three staff (Staff A and C) had provided the required documentation for completing ( ) training. Findings include: On in a record review of Staff A's employee file, Staff A's file documented a hire date of . Staff A's file failed to provide documentation Staff A had completed the required training. On . in a record review of Staff C's employee file, Staff C's file documented a hire date of . Staff C's file failed to provide documentation of Staff C had completed the required . training. On at 12:20 PM, in an interview with the administrator, the administrator stated the files she provided for employee records are	A 090		

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A 090	Continued From page 20 complete and she does not understand why the records are not in the files. Class III	A 090		
A 165 SS=D	429.23(&) FS; 58A-5.0241 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or	A 165		

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A 165	Continued From page 21 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply.	A 165		

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A 165	Continued From page 22 (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The Department of Elderly Affairs may adopt rules necessary to administer this section. 58A-5.0241 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by Section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to Rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1) above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to Rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to submit an adverse incident report within the required 24-hours of the incident. Findings include: On in a record review of the Agency for Health Care Administration (AHCA) Adverse	A 165		

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A 165	Continued From page 23 Incident Reporting System (AIRS), AIRS documented the administrator filed a report on [redacted] at 6:00 PM for an elopement incident which occurred on [redacted] at 6:15 PM. The AIRS documents the facility address as 2638 Jupiter Blvd SW, Palm Bay, Florida. On [redacted] in a record review of local law enforcement reports, the law enforcement report documents the incident involving the elopement of a resident, occurred on [redacted] at 6:15 PM. The law enforcement report documents the incident occurred at 2306 Woodlawn Circle, Melbourne, Florida, and law enforcement were called to investigate. On [redacted] at 10:18 AM, in an interview with Staff B, Staff B stated the incident occurred during a holiday party on [redacted] at 2306 Woodlawn Circle, Melbourne, Florida. On [redacted] at 12:20 PM, in an interview with the administrator, the administrator stated the incident report was sent to the AIRS system late. The administrator stated the incident occurred at 2306 Woodlawn Circle, Melbourne, not the 2638 Jupiter Blvd SW, Palm Bay, address. Class III	A 165		