

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/05/2019
NAME OF PROVIDER OR SUPPLIER TYVAL ASSISTED LIVING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 3526 GENEVRA AVE BOYNTON BEACH, FL 33436		
(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)	
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 _____ 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 _____ 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; _____; 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 update the Agency for Background Screening Clearinghouse Employee Roster in a timely manner for 4 of 5 sampled staff (Staff B, D, E and F).	CZ814		

AHCA Form 3020-0001

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

TITLE

(X8) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/05/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TYVAL ASSISTED LIVING FACILITY

**3526 GENEVRA AVE
BOYNTON BEACH, FL 33436**

(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	Continued From page 1 The findings included: On at approximately 10:30 AM, review of the facility's background screening clearinghouse roster revealed Staff B, whose hire date was was not registered in the clearinghouse. Further review revealed Staff D, E, and F were listed on the roster. In an interview at this time, the Administrator stated they no longer work for the facility, and are not on the facility schedule. The actual end dates for Staff D, E, and F were not provided. During an interview with the Administrator on at approximately 2:20 PM, she acknowledged the findings and provided no additional documentation for review. 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 to the Federal Bureau of Investigation for a national criminal history record check unless the person's are enrolled in the Federal Bureau of Investigation's national retained print notification program. If the of	CZ816		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/05/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TYVAL ASSISTED LIVING FACILITY

**3526 GENEVRA AVE
BOYNTON BEACH, FL 33436**

(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
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 electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the _____ to the Federal Bureau of Investigation for a national criminal history record check. The _____ 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 _____. 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 _____, 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		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/05/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TYVAL ASSISTED LIVING FACILITY

**3526 GENEVRA AVE
BOYNTON BEACH, FL 33436**

(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
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		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/05/2019
NAME OF PROVIDER OR SUPPLIER TYVAL ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 GENEVRA AVE BOYNTON BEACH, FL 33436		
(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	
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 ensure all staff completed Agency for Healthcare Administration Background Screening Attestation of Compliance forms for 3 of 3 sampled staff (Staff A, B and C). The findings included: On _____ at approximately 1:00 PM, record reviews for Staff A, hired on _____, Staff B, hired on _____, and Staff C, hired on _____, revealed no signed and dated Background Screening Attestation of Compliance forms (AHCA Form 3100-0008 _____), in their employee files. Further review revealed Staff A, B and C had current eligible Level II background screenings on file. At this time, the facility was provided an opportunity to locate the documentation. On _____ at approximately 1:20 PM, the Administrator acknowledged the findings and provided no additional documentation for review.	CZ816			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/05/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TYVAL ASSISTED LIVING FACILITY

**3526 GENEVRA AVE
BOYNTON BEACH, FL 33436**

(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
CZ816	Continued From page 5 Class III	CZ816		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/05/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TYVAL ASSISTED LIVING FACILITY

**3526 GENEVRA AVE
BOYNTON BEACH, FL 33436**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced relicensure survey was conducted on 8/5/19 at Tyval Assisted Living Facility. There were deficiencies at the time of the survey.	A 000		
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 _____ 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 _____	A 052		

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/05/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TYVAL ASSISTED LIVING FACILITY

**3526 GENEVRA AVE
BOYNTON BEACH, FL 33436**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 052	Continued From page 1 ... 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. (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.	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/05/2019
NAME OF PROVIDER OR SUPPLIER TYVAL ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 GENEVRA AVE BOYNTON BEACH, FL 33436		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 052	Continued From page 2 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 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,	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/05/2019
NAME OF PROVIDER OR SUPPLIER TYVAL ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 GENEVRA AVE BOYNTON BEACH, FL 33436		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 052	Continued From page 3 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 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 record review an interviews, the facility failed to ensure that one staff member with current certification in First Aid was present in the facility at all times. The findings included: On _____, upon arrival to the facility at approximately 9:00 AM, Staff A and Staff B were	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/05/2019
NAME OF PROVIDER OR SUPPLIER TYVAL ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 GENEVRA AVE BOYNTON BEACH, FL 33436		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 052	Continued From page 4 observed providing care for the residents. During record review at approximately 1:00 PM, there was no current First Aid certification on file for either Staff A or Staff B. At this time, the Administrator was provided an opportunity to locate the documentation. On _____ at approximately 2:15 PM, the Administrator acknowledged the findings and provide no additional documentation for review. 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,	A 054			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/05/2019
NAME OF PROVIDER OR SUPPLIER TYVAL ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 GENEVRA AVE BOYNTON BEACH, FL 33436		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 054	Continued From page 5 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical _____, the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure resident Medication Observation Records (MOR) were updated immediately after the residents received routine and "as needed" medications for 5 of 5 sampled residents (Resident #'s 1, 2, 3, 4 and 5). The findings included: On _____ at approximately 9:30 AM, the facility MOR's were reviewed for following residents: For Resident #1, the _____ through _____ MOR's were reviewed and revealed Resident #1 receives _____ 8.6 milligrams (MG), _____ D3 2000 units. Further review revealed no staff initials on the MOR documenting these medications were given on _____ at 8:00 AM. Review of the actual medication package revealed the medication was given for _____ Interview with Staff A at this time verified the medication had been given to the resident; she stated the MOR's were not initialed. For Resident #2, the _____ through _____ MOR's were reviewed and revealed Resident #5 receives _____ HCl 500 MG twice a day, at 8:00 AM and 5:00 PM, _____ 25 MG twice a day at 8:00 AM and 8:00 PM, and _____ D3 daily at 8:00 AM. Further review revealed no	A 054			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/05/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TYVAL ASSISTED LIVING FACILITY

**3526 GENEVRA AVE
BOYNTON BEACH, FL 33436**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 054	Continued From page 6 staff initials on the MOR documenting medication was given for the evening of _____, and the morning and evening of _____. _____, and the morning of _____. At this time, during an interview with the Administrator, she stated the resident was in the hospital on _____. The actual medication package was reviewed and revealed medications missing from the medication package were consistent with the resident being out of the facility on the evenings of _____ and _____. For Resident #3, the _____ through _____ MOR's were reviewed and revealed Resident #3 receives _____, 12.5 MG twice a day, _____, 10 MG daily, _____, 50 MG twice a day. Further review revealed no staff initials on the MOR documenting medication given _____ at 8:00 AM. Review of the actual medication package verified medication was given for _____. Interview with Staff A at this time verified the medication had been given to the resident; she stated the MOR's were not initialed. For Resident #4, the _____ through _____ MOR's were reviewed and revealed Resident #4 receives _____, 40 MG daily, _____, CL ER 10 milliequivalents (MEQ) daily, _____, 16 MG daily, _____, 88 micrograms (MCG) daily, _____, 2 MG daily, _____, 81 MG daily, _____, 100 MG daily, and _____, D3 2000 units. Further review revealed no staff initials on the MOR documenting medication was given on _____ at 8:00 AM. Review of the actual medication package verified medication was given for _____. Interview with Staff A at this time verified the medication had been given to the resident; she stated the MOR's were not initialed.	A 054		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/05/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TYVAL ASSISTED LIVING FACILITY

**3526 GENEVRA AVE
BOYNTON BEACH, FL 33436**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 054	Continued From page 7 For Resident #5, the _____ through MOR's were reviewed and revealed Resident #5 received MAPAP 500 MG three times a day "as needed". Further review of the MOR revealed Resident #5 received this medication on and _____. The MOR did not contain any documentation on the _____ of the MOR showing the dates, times, reason and results for the "as needed" medications for these two dates. The Administrator was observed documenting the _____ dose at the time this surveyor requested the MOR's for review. Class III	A 054		
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. 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	A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/05/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TYVAL ASSISTED LIVING FACILITY

**3526 GENEVRA AVE
BOYNTON BEACH, FL 33436**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 078	Continued From page 8 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 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	A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/05/2019
NAME OF PROVIDER OR SUPPLIER TYVAL ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 GENEVRA AVE BOYNTON BEACH, FL 33436		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 078	Continued From page 9 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 all staff received a written statement from a Health Care Provider (HCP) documenting no sign or symptoms of communicable (.) for 1 of 3 sampled staff (Staff B). The findings included: On at approximately 12:30 PM, Staff B's employee record was reviewed and revealed Staff B was hired on Further review revealed no documentation of a written statement from a HCP documenting no signs or symptoms of communicable including The Administrator provided a copy of a but no documentation regarding signs or symptoms communicable including was attached. At this time, the Administrator was provided an opportunity to locate the documentation. During an interview with the Administrator on at approximately 2:15 PM, she acknowledged the findings and provided no additional documentation for review. 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	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/05/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TYVAL ASSISTED LIVING FACILITY

**3526 GENEVRA AVE
BOYNTON BEACH, FL 33436**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 081	Continued From page 10 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 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 blood borne pathogens, 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:	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/05/2019
NAME OF PROVIDER OR SUPPLIER TYVAL ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 GENEVRA AVE BOYNTON BEACH, FL 33436		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 081	Continued From page 11 - Reporting adverse incidents. - 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: - Resident rights in an assisted living facility. - 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: - Resident behavior and needs. - Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. - All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. - All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures.	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/05/2019
NAME OF PROVIDER OR SUPPLIER TYVAL ASSISTED LIVING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 3526 GENEVRA AVE BOYNTON BEACH, FL 33436			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 081	Continued From page 12 This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure all staff received required in-service training within the first 30 days of hire for 3 of 3 sampled staff (Staff A, B and C). The findings included: On at approximately 12:30 PM, employee record reviewed revealed the following: Staff B, whose hire date was, and Staff C, whose hire date was had no certificate of completion for Pre-Service Orientation. Staff A, whose hire date was, Staff B and Staff C had no certificates of completion for Elopement Response Training. Staff B and Staff C had no certificates of completion for training Incident Reporting, Major Incident Reporting, Adverse Incident Reporting, and the facility Emergency Response policy and procedures. At this time the Administrator was provided an opportunity to locate the documentation. During an interview with the Administrator on at approximately 2:15 PM, she acknowledged the findings and provided no additional documentation for review. Class III	A 081			
A 083 SS=D	58A-5.0191(5) FAC Training - First Aid and	A 083			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/05/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TYVAL ASSISTED LIVING FACILITY

**3526 GENEVRA AVE
BOYNTON BEACH, FL 33436**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 083	Continued From page 13 (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 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 review and interviews, the facility failed to ensure that a First Aid certified direct care staff person was on duty in the facility at all times. The findings included: On, upon arrival at approximately 9:00 AM, Staff A and Staff B were observed providing care for the residents. Employee record review conducted at approximately 1:00 PM revealed no current First Aid certification on file for Staff A and Staff B. At this time, the Administrator was provided an opportunity to locate the documentation.	A 083		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/05/2019
NAME OF PROVIDER OR SUPPLIER TYVAL ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 GENEVRA AVE BOYNTON BEACH, FL 33436		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 083	Continued From page 14 During an interview with the Administrator on _____ at approximately 2:15 PM, she acknowledged the findings and provided no additional documentation for review. Class III	A 083			
A 084 SS=D	58A-5.0191(6) FAC 429.52 (6), FS Training - Assis Self-Admin Meds & Med Mgmt 58A-5.0191 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 58A-5.0185, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfillment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for _____ control, and	A 084			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/05/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TYVAL ASSISTED LIVING FACILITY

**3526 GENEVRA AVE
BOYNTON BEACH, FL 33436**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 084	Continued From page 15 ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 58A-5.0185, F.A.C., including: a. Assist with oral dosage forms, _____ dosage forms, and _____ and _____ dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with _____ syringes that are prefilled with the proper dosage by a pharmacist and _____ that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection; i. Assist with _____; j. Use a _____ to perform _____	A 084		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/05/2019
NAME OF PROVIDER OR SUPPLIER TYVAL ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 GENEVRA AVE BOYNTON BEACH, FL 33436		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 084	Continued From page 16 testing; k. Assist residents with _____ and continuous positive airway pressure (CPAP) devices, excluding the titration of the _____ levels; i. Apply and remove _____ stockings and hosiery; m. Placement and removal of _____ bags, excluding the removal of the _____ or manipulation of the _____ site; and, n. Measurement of _____ rate, temperature, and _____ rate. (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6), FS (6) Staff involved with the management of medications and assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6	A 084			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/05/2019
NAME OF PROVIDER OR SUPPLIER TYVAL ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 GENEVRA AVE BOYNTON BEACH, FL 33436		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 084	Continued From page 17 additional hours of training provided by a registered nurse, licensed pharmacist, or department staff. The department shall establish by rule the minimum requirements of this additional training. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure all staff who provide assistance with self-administration of medication received the required medication training for 1 of 3 sampled staff (Staff B). The findings included: On at approximately 9:10 AM, an interview with Staff B revealed she assists residents with self-administration of medications. Employee record review for Staff B revealed a Medication Training certificate dated for 4 hours. The credentials of the instructor were not legible on the certificate. There was no documentation showing Staff B received the required 6 hours of initial training by a registered nurse or licensed pharmacist. At this time, the Administrator was provided an opportunity to locate the documentation. During an interview with the Administrator on at approximately 2:20 PM, she acknowledged the findings and provided no additional documentation for review.	A 084			
A 090 SS=D	58A-5.0191(11) FAC Training - (11) TRAINING.	A 090			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11667048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/05/2019
NAME OF PROVIDER OR SUPPLIER TYVAL ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 GENEVRA AVE BOYNTON BEACH, FL 33436		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 090	Continued From page 18 (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 review and interviews, the facility failed to ensure that all staff received training on facility policy and procedures regarding _____ within the first 30 days of hire for 2 of 3 sampled staff (Staff B and C). The findings included: On _____ at approximately 1:00 PM, an employee record review was conducted for Staff B whose hire date was _____, and Staff C whose hire date was _____. The review revealed no certificate of completion of training related to facility policy and procedures regarding Do No _____ Orders. At this time, the Administrator was provided an opportunity to locate the documentation. During an interview with the Administrator on _____ at approximately 2:20 PM, she acknowledged the findings and provided no	A 090			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/05/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TYVAL ASSISTED LIVING FACILITY

**3526 GENEVRA AVE
BOYNTON BEACH, FL 33436**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 090	Continued From page 19 additional documentation for review. Class III	A 090		
A 200 SS=D	58A-5.036 FAC Emergency Environmental Control (1) DETAILED EMERGENCY ENVIRONMENTAL CONTROL PLAN. Each assisted living facility shall prepare a detailed plan ("plan") to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency environmental control in the event of the loss of primary electrical power in that assisted living facility which includes the following information: (a) The acquisition of a sufficient alternate power source such as a generator(s), maintained at the assisted living facility, to ensure that current licensees of assisted living facilities will be equipped to ensure air temperatures will be maintained at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. 1. The required temperature must be maintained in an area or areas, determined by the assisted living facility, of sufficient size to maintain residents safely at all times and that is appropriate for resident care needs and life safety requirements. For planning purposes, no less than twenty (20) net square per resident must be provided. The assisted living facility may use eighty percent (80%) of its licensed bed capacity as the number of residents to be used in the to determine the required square footage. This may include areas that are less than the entire assisted living facility if the assisted living facility's comprehensive emergency management plan includes allowing a resident to congregate when he or she desires in	A 200		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/05/2019
NAME OF PROVIDER OR SUPPLIER TYVAL ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 GENEVRA AVE BOYNTON BEACH, FL 33436		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 200	Continued From page 20 portions of the building where temperatures will be maintained and includes procedures for monitoring residents for signs of heat related injury as required by this rule. This rule does not prohibit a facility from acting as a receiving provider for evacuees when the conditions stated in Section 408.821, F.S., and subsection 58A-5.026(5), F.A.C., are met. The plan shall include information regarding the area(s) within the assisted living facility where the required temperature will be maintained. 2. The alternate power source and fuel supply shall be located in an area(s) in accordance with local zoning and the Florida Building Code. 3. Each assisted living facility is unique in size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and staffing characteristics. Accordingly, this rule does not limit the types of systems or equipment that may be used to achieve temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. The plan shall include information regarding the systems and equipment that will be used by the assisted living facility and the fuel required to operate the systems and equipment. a. An assisted living facility in an evacuation zone pursuant to Chapter 252, F.S., must maintain an alternative power source and fuel as required by this subsection at all times when the assisted living facility is occupied but is permitted to utilize a mobile generator(s) to enable portability if evacuation is necessary. b. Assisted living facilities located on a single campus with other facilities under common ownership, may share fuel, alternative power resources, and resident space available on the	A 200			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/05/2019
NAME OF PROVIDER OR SUPPLIER TYVAL ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 GENEVRA AVE BOYNTON BEACH, FL 33436		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 200	Continued From page 21 campus if such resources are sufficient to support the requirements of each facility's residents, as specified in this rule. Details regarding how resources will be shared and any necessary movement of residents must be clearly described in the emergency power plan. c. A multistory facility, whose comprehensive emergency management plan is to move residents to a higher floor during a flood or surge event, must place its alternative power source and all necessary additional equipment so it can safely operate in a location protected from flooding or storm surge damage. (b) The acquisition of sufficient fuel, and safe maintenance of that fuel at the facility, to ensure that in the event of the loss of primary electrical power there is sufficient fuel available for the alternate power source to maintain temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours after the loss of primary electrical power during a declared state of emergency. The plan must include information regarding fuel source and fuel storage. 1. Facilities must store minimum amounts of fuel onsite as follows: a. A facility with a licensed capacity of 16 beds or less must store 48 hours of fuel onsite. b. A facility with a licensed capacity of 17 or more beds must store 72 hours of fuel onsite. 2. An assisted living facility located in an area in a declared state of emergency area pursuant to Section 252.36, F.S., that may impact primary power delivery must secure ninety-six (96) hours of fuel. The assisted living facility may utilize portable fuel storage containers for the remaining fuel necessary for ninety-six (96) hours during the period of a declared state of emergency. 3. Piped natural gas is an allowable fuel source	A 200			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/05/2019
NAME OF PROVIDER OR SUPPLIER TYVAL ASSISTED LIVING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 3526 GENEVRA AVE BOYNTON BEACH, FL 33436			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 200	Continued From page 22 and meets the onsite fuel supply requirements under this rule. 4. If local ordinances or other regulations limit the amount of onsite fuel storage for the assisted living facility's location, then the assisted living facility must develop a plan that includes maximum onsite fuel storage allowable by the ordinance or regulation and a reliable method to obtain the maximum additional fuel at least 24 hours prior to depletion of onsite fuel. (c) The acquisition of services necessary to maintain, and test the equipment and its functions to ensure the safe and sufficient operation of the alternate power source maintained at the assisted living facility. (d) The acquisition and maintenance of a monoxide alarm. (2) SUBMISSION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall submit its plan to the local emergency management agency for review within 30 days of the effective date of this rule. Assisted living facility plans previously submitted and approved pursuant to Emergency Rule 58AER17-1, F.A.C., will require resubmission only if changes are made to the plan. (b) Each new assisted living facility shall submit the plan required under this rule prior to obtaining a license. (c) Each existing assisted living facility that undergoes any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of its systems or equipment affecting the facility's compliance with this rule shall amend its plan and submit it to the local emergency management agency for review and approval. (3) APPROVED PLANS.	A 200			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/05/2019
NAME OF PROVIDER OR SUPPLIER TYVAL ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 GENEVRA AVE BOYNTON BEACH, FL 33436		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 200	Continued From page 23 (a) Each assisted living facility must maintain a copy of its approved plan in a manner that makes the plan readily available at the licensee's physical address for review by a legally authorized entity. If the plan is maintained in an electronic format, assisted living facility staff must be readily available to access and produce the plan. For purposes of this section, "readily available" means the ability to immediately produce the plan, either in electronic or paper format, upon request. (b) Within two (2) business days of the approval of the plan from the local emergency management agency, the assisted living facility shall submit in writing proof of the approval to the Agency for Health Care Administration. (c) The assisted living facility shall submit a consumer-friendly summary of the emergency power plan to the Agency. The Agency shall post the summary and notice of the approval and implementation of the assisted living facility emergency power plans on its website within ten (10) business days of the plan's approval by the local emergency management agency and update within ten (10) business days of implementation. (4) IMPLEMENTATION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall, no later than _____, have implemented the plan required under this rule. (b) The Agency shall allow an extension up to _____ to providers in compliance with subsection (c), below, and who can show delays caused by necessary construction, delivery of ordered equipment, zoning or other regulatory approval processes. Assisted living facilities shall notify the Agency that they will utilize the extension and keep the Agency apprised of	A 200			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/05/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TYVAL ASSISTED LIVING FACILITY

**3526 GENEVRA AVE
BOYNTON BEACH, FL 33436**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 200	Continued From page 24 progress on a quarterly basis to ensure there are no unnecessary delays. If an assisted living facility can show in its quarterly progress reports that unavoidable delays caused by necessary construction, delivery of ordered equipment, zoning or other regulatory approval processes will occur beyond the initial extension date, the assisted living facility may request a waiver pursuant to Section 120.542, F.S. (c) During the extension period, an assisted living facility must make arrangements pending full implementation of its plan that provides the residents with an area or areas to congregate that meets the safe indoor air temperature requirements of paragraph (1)(a), for a minimum of ninety-six (96) hours. 1. An assisted living facility not located in an evacuation zone must either have an alternative power source onsite or have a contract in place for delivery of an alternative power source and fuel when requested. Within twenty-four (24) hours of the issuance of a state of emergency for an event that may impact primary power delivery for the area of the assisted living facility, it must have the alternative power source and no less than ninety-six (96) hours of fuel stored onsite. 2. An assisted living facility located in an evacuation zone pursuant to Chapter 252, F.S., must either: a. Fully and safely evacuate its residents prior to the arrival of the event, or b. Have an alternative power source and no less than ninety-six (96) hours of fuel stored onsite, within twenty-four (24) hours of the issuance of a state of emergency for the area of the assisted living facility. (d) Each new assisted living facility shall implement the plan required under this rule prior to obtaining a license.	A 200		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/05/2019
NAME OF PROVIDER OR SUPPLIER TYVAL ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 GENEVRA AVE BOYNTON BEACH, FL 33436		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 200	Continued From page 25 (e) Existing assisted living facilities that undergo any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of the systems or equipment affecting the assisted living facility's compliance with this rule shall implement its amended plan concurrent with any such additions, modifications, alterations, refurbishment, renovations or reconstruction. (f) The Agency for Health Care Administration may request cooperation from the State Fire Marshal to conduct inspections to ensure implementation of the plan in compliance with this rule. (5) POLICIES AND PROCEDURES. (a) Each assisted living facility shall develop and implement written policies and procedures to ensure that the assisted living facility can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. The procedures shall ensure that residents do not experience complications from fluctuations in _____ air temperatures inside the facility. Procedures must address the care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury including: 1. The use of cooling devices and equipment; 2. The use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration; 3. Wellness checks by assisted living facility staff to monitor for signs of _____ and heat injury; and, 4. A provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy.	A 200			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/05/2019
NAME OF PROVIDER OR SUPPLIER TYVAL ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 GENEVRA AVE BOYNTON BEACH, FL 33436		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 200	Continued From page 26 (b) Each assisted living facility shall maintain the written policies and procedures in a manner that makes them readily available at the licensee's physical address for review by a legally authorized entity. If the policies and procedures are maintained in an electronic format, assisted living facility staff must be readily available to access the policies and procedures and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce the policies and procedures, either in electronic or paper format, upon request. (c) The written policies and procedures must be readily available for inspection by each resident; each resident's legal representative, designee, surrogate, guardian, attorney in fact, or case manager; each resident's estate; and such additional parties as authorized in writing or by law. (6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this rule, the Agency for Health Care Administration may seek any remedy authorized by Chapter 429, Part I, F.S., or Chapter 408, Part II, F.S., including, but not limited to, license revocation, license suspension, and the imposition of administrative fines. (7) COMPREHENSIVE EMERGENCY MANAGEMENT PLAN. (a) Assisted living facilities whose comprehensive emergency management plan is to evacuate must comply with this rule. (b) Each facility whose plan has been approved shall submit the plan as an addendum with any future submissions for approval of its comprehensive emergency management plan. (8) NOTIFICATION. (a) Within five (5) business days, each assisted living facility must notify in writing, unless	A 200			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/05/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TYVAL ASSISTED LIVING FACILITY

**3526 GENEVRA AVE
BOYNTON BEACH, FL 33436**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 200	Continued From page 27 permission for electronic communication has been granted, each resident and the resident's legal representative: 1. Upon submission of the plan to the local emergency management agency that the plan has been submitted for review and approval; 2. Upon final implementation of the plan by the assisted living facility. (b) Each assisted living facility must maintain a copy of each notification set forth in paragraph (a), above, in a manner that makes each notification readily available at the licensee's physical address for review by a legally authorized entity. If the notifications are maintained in an electronic format, facility staff must be readily available to access and produce the notifications. For purposes of this section, "readily available" means the ability to immediately produce the notifications, either in electronic or paper format, upon request. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to notify residents and their representatives of the facility's implementation of their Environmental Emergency Power Plan (EECP). The findings included: On _____, at approximately 11:00 AM, the facility's county-approved EECP was reviewed and revealed no documentation of written notification given to residents and their representatives of the facility's implementation of their EECP. The facility EECP was approved and implemented on _____. At this time, the Administrator was provided an opportunity to locate the documentation.	A 200		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/05/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TYVAL ASSISTED LIVING FACILITY

**3526 GENEVRA AVE
BOYNTON BEACH, FL 33436**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 200	Continued From page 28 During an interview with the Administrator on at approximately 2:20 PM, she acknowledged the findings and provided no additional documentation for review. Class III	A 200		
AE210 SS=D	58A-5.0191(8) FAC ECC - Training (8) EXTENDED CONGREGATE CARE (ECC) TRAINING. (a) The administrator and ECC supervisor, if different from the administrator, must complete core training and 4 hours of initial training in extended congregate care prior to the facility receiving its ECC license or within 3 months of beginning employment in a currently licensed ECC facility as an administrator or ECC supervisor. Successful completion of the assisted living facility core training shall be a prerequisite for this training. ECC supervisors who attended the assisted living facility core training prior to , shall not be required to take the assisted living facility core training competency test. (b) The administrator and the ECC supervisor, if different from the administrator, must complete a minimum of 4 hours of continuing education every two years in topics relating to the physical, , or social needs of frail elderly and persons, or persons with's or related (c) All direct care staff providing care to residents in an ECC program must complete at least 2 hours of in-service training, provided by the facility administrator or ECC supervisor, within 6 months of beginning employment in the facility. The training must address ECC concepts and requirements, including statutory and rule	AE210		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/05/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TYVAL ASSISTED LIVING FACILITY

**3526 GENEVRA AVE
BOYNTON BEACH, FL 33436**

(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
AE210	Continued From page 29 requirements, and the delivery of personal care and supportive services in an ECC facility. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that all staff received the required Limited Mental Health (LMH) training within 6 months of hire, and failed to ensure bi-annual 2 hour updates were completed for 2 of 3 sampled staff (Staff A and C). The findings included: On _____ at approximately 1:20 PM, employee record reviews revealed Staff A, whose hire date was _____, received her initial 6 hours LMH training on _____; there was no 2 hour update certificate on file. Further review revealed Staff C, whose hire date was _____ had no certificate of completion for LMH training. During an interview with the Administrator on 08/05/2019 at approximately 2:25 PM, she stated she was not aware that she still had the LMH license, as she has not had any LMH residents for a long time. She acknowledged the findings and provided no additional documentation for review. Class III	AE210		