

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                        |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11965789</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/17/2019</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**TERRACE COMMUNITIES TEQUESTA,**

**400 NORTH US ONE  
TEQUESTA, FL 33469**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 000                    | Initial Comments<br><br>An unannounced Relicensure with Extended Congregate Care (ECC) survey was conducted on _____ at Terrace Communities Tequesta. The facility had deficiencies at the time of the survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | A 000               |                                                                                                                          |                          |
| A 010<br>SS=D            | 429.26( &9) FS; 59A-36.006(4) FAC<br>Admissions - Continued Residency<br><br>429.26<br>(1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination shall be based upon an assessment of the strengths, needs, and preferences of the resident, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.<br>(2) A physician, physician assistant, or nurse practitioner who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interest in the facility.<br>(9) A _____, ill resident who no longer meets | A 010               |                                                                                                                          |                          |

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                |                                                                                                                          |  |                                                        |
|--------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11965789</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/17/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TERRACE COMMUNITIES TEQUESTA,</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>400 NORTH US ONE<br/>TEQUESTA, FL 33469</b>                                  |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 010                                                                    | <p>Continued From page 1</p> <p>the criteria for continued residency may remain in the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident are being met.</p> <p>59A-36.006</p> <p>(4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a ...-to-... medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 59A-36.002, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are:</p> <p>(a) The resident may be bedridden for no more than 7 consecutive days.</p> <p>(b) A resident requiring care of a ... may be retained provided that:</p> <ol style="list-style-type: none"> <li>1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider,</li> <li>2. The condition is documented in the resident's record; and,</li> <li>3. If the resident's condition fails to improve within 30 days, as documented by a health care</li> </ol> | A 010                                                                          |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                |                                                                                                                          |  |                                                        |
|--------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11965789</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/17/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TERRACE COMMUNITIES TEQUESTA,</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>400 NORTH US ONE<br/>TEQUESTA, FL 33469</b>                                  |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 010                                                                    | <p>Continued From page 2</p> <p>provider, the resident must be discharged from the facility.</p> <p>(c) A . . . . ., ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met:</p> <ol style="list-style-type: none"> <li>1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need;</li> <li>2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency;</li> <li>3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and,</li> <li>4. Documentation of the requirements of this paragraph is maintained in the resident's file.</li> </ol> <p>(d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times.</p> <p>(e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license.</p> <p>(f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training.</p> <p>(g) Continued residency criteria for facilities holding an extended congregate care license are described in rule 59A-36.021, F.A.C.</p> | A 010                                                                          |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                        |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11965789</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/17/2019</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**TERRACE COMMUNITIES TEQUESTA,**

**400 NORTH US ONE  
TEQUESTA, FL 33469**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 010                    | <p>Continued From page 3</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on observation, record review and interviews, the facility failed to monitor the continued appropriateness of residency in this assisted living facility (ALF) for 2 out of 2 sampled residents (Resident #1 &amp; #10).</p> <p>The findings included:</p> <p>a) On _____ at 11:30 AM, the DON (Director of Nursing) stated during interview that Resident #10 had a pressure injury and that a home health agency (HHA) cared for the _____. She stated that the _____ was a pressure injury that reopened within the past week.</p> <p>Review of the resident's Observation Notes and health care provider's orders revealed a note and an order for a home health agency to "evaluate and treat a weeping 3 x 3 cm on right _____ open area" dated _____. The DON stated this was a _____ pressure injury.</p> <p>Review of the resident's health assessment (AHCA Form 1823) dated _____ showed the resident had no pressure injuries at that time. There was no health assessment on file that showed the resident's current _____ pressure injury or the pressure injury that was identified on _____, a significant change that requires a new health assessment to be completed.</p> <p>The monitoring of the resident's appropriateness for continued residency, as documented on a new health assessment (AHCA Form 1823) for the resident, was not completed as required when the resident experienced a significant change, the onset of a _____ pressure injury.</p> | A 010               |                                                                                                                          |                          |

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                        |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11965789</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/17/2019</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**TERRACE COMMUNITIES TEQUESTA,**

**400 NORTH US ONE  
TEQUESTA, FL 33469**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 010                    | <p>Continued From page 4</p> <p>These findings were discussed with the Administrator and DON on _____ at 12:15 PM. The facility provided no additional documentation for review at this time.</p> <p>b) Resident #1 was admitted to the facility on _____. He was admitted to hospice services on _____. Review of his records conducted on _____ and _____ revealed the following:</p> <p>1. His resident observation notes revealed:</p> <p>a. A note dated _____ documented an open area to his right _____ described as a _____.</p> <p>b. A note dated _____ documented clean open area on _____ with _____ cleanser, _____ dry, then apply thin hydrocolloid _____ two times a week until healed; cushion on recliner chair to prevent further _____ and facilitate healing; encourage to re-position frequently side-to-side in bed.</p> <p>c. A note dated _____ right and left areas re-opened, called hospice regarding re-starting _____ care order.</p> <p>d. A note dated _____ discontinue _____ care order ... clean both _____ with _____ cleanser, _____ dry, apply thick hydrocolloid two times weekly until healed.</p> <p>e. A note dated _____ documented _____ care, clean open area on both _____ with normal _____, then apply _____ cream _____, cover with _____, wrap with kling and secure with tape two times weekly and as needed until healed.</p> <p>g. From _____ through _____, the resident observation notes contained multiple entries describing the resident's refusal of care and meals (and taking nutritional supplements), and non-compliance with re-positioning.</p> <p>2. His Initial Integrated Plan of Care dated _____</p> | A 010               |                                                                                                                          |                          |

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                        |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11965789</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/17/2019</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**TERRACE COMMUNITIES TEQUESTA,**

**400 NORTH US ONE  
TEQUESTA, FL 33469**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 010                    | <p>Continued From page 5</p> <p>... documented a pre-printed section that was checked off as applicable to this resident. "Skin Integrity - Need for Observation/Assessment of Skin; Facility and Hospice Nurse to observe and assess integumentary status for early identification of complications. (include specifics for ... care if applicable)". The care plan failed to include the specifics of the resident's status related to open to this and heels. There was a lack of information documenting the specific type, size and status of the ...</p> <p>3. His ... records revealed: ... at ... at ... and ... at ... A pre-printed section that was not checked off disclosed, "Altered Nutrition/Hydration - Need for Observation/Assessment of Nutrition/Hydration" Further review of the care plan revealed no additional information related to the resident's significant change in ... status.</p> <p>4. His AHCA Form 1823 (health examination) dated ... did not document that he was receiving hospice end-of-life services (effective ...). Also, Resident #1 experienced a significant change in ... recorded in ... that was not reflected on any health examination.</p> <p>These concerns were discussed with the facility's Administrator and Health Services Director on ... at 1:45 PM, and on ... at 11:07 AM.</p> <p>Class III</p> | A 010               |                                                                                                                          |                          |

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                        |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11965789</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/17/2019</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**TERRACE COMMUNITIES TEQUESTA ,**

**400 NORTH US ONE  
TEQUESTA, FL 33469**

| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 078<br><br>A 078<br>SS=D | Continued From page 6<br><br>59A-36.010(2) FAC Staffing Standards - Staff<br><br>(2) STAFF.<br>(a) Within 30 days after beginning employment,<br>newly hired staff must submit a written statement<br>from a health care provider documenting that the<br>individual does not have any signs or symptoms<br>of communicable . The examination<br>performed by the health care provider must have<br>been conducted no earlier than 6 months before<br>submission of the statement. Newly hired staff<br>does not include an employee transferring without<br>a break in service from one facility to another<br>when the facility is under the same management<br>or ownership.<br>1. Evidence of a negative<br>examination must be documented on an annual<br>basis. Documentation provided by the Florida<br>Department of Health or a licensed health care<br>provider certifying that there is a shortage of<br>..... testing materials satisfies the annual<br>..... examination requirement. An<br>individual with a positive ..... test must<br>submit a health care provider's statement that the<br>individual does not constitute a risk of<br><br>2. If any staff member has, or is suspected of<br>having, a communicable ....., such individual<br>must be immediately removed from duties until a<br>written statement is submitted from a health care<br>provider indicating that the individual does not<br>constitute a risk of transmitting a communicable<br>.....<br>(b) Staff must be qualified to perform their<br>assigned duties consistent with their level of<br>education, training, preparation, and experience.<br>Staff providing services requiring licensing or<br>certification must be appropriately licensed or<br>certified. All staff must exercise their | A 078<br><br>A 078  |                                                                                                                          |                          |

Agency for Health Care Administration

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                |                                                                                                                          |                          |                                                        |
|--------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11965789</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/17/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TERRACE COMMUNITIES TEQUESTA,</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>400 NORTH US ONE<br/>TEQUESTA, FL 33469</b>                                  |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 078                                                                    | <p>Continued From page 7</p> <p>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.</p> <p>(c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C.</p> <p>(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.</p> <p>(e) For facilities with a licensed capacity of 17 or more residents, the facility must:</p> <ol style="list-style-type: none"> <li>1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and,</li> <li>2. Maintain time sheets for all staff.</li> </ol> <p>(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.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and an interview, the facility failed to ensure 1 out of 3 sampled staff had submitted a written statement from a health care provider dated within the previous year, documenting that the individual does not have { }.</p> <p>The findings included:</p> <p>On at 11:00 AM, the personnel file for Staff C was reviewed. The file did not contain a written statement from a health care provider</p> | A 078                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                        |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11965789</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/17/2019</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**TERRACE COMMUNITIES TEQUESTA ,**

**400 NORTH US ONE  
TEQUESTA, FL 33469**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 078                    | Continued From page 8<br><br>dated within the previous year, documenting that this employee was free from . The last documentation that the employee was free from was dated .<br><br>The Business Office Manager was notified of these findings on . . . at 11:30 AM. The facility provided no additional documentation for review at this time.<br><br>Class III                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | A 078               |                                                                                                                          |                          |
| A 085<br>SS=D            | 59A-36.011(7) FAC Training - Nutrition & Food Service<br><br>(7) NUTRITION AND FOOD SERVICE. The administrator or person designated by the administrator as responsible for the facility's food service and the day-to-day supervision of food service staff must obtain, annually, a minimum of 2 hours continuing education in topics pertinent to nutrition and food service in an assisted living facility. This requirement does not apply to administrators and designees who are exempt from training requirements under paragraph 59A-36.012(1)(b). A certified food manager, licensed dietician, registered dietary technician or health department sanitarian is qualified to train assisted living facility staff in nutrition and food service.<br><br>This Statute or Rule is not met as evidenced by: Based on record review and an interview, the facility failed to ensure that 1 out of 1 sampled staff member (Staff F) who was responsible for the facility's food service and the day-to-day supervision of food service staff had obtained a minimum of 2 hours of education annually in topics pertinent to nutrition and food service in an | A 085               |                                                                                                                          |                          |

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                        |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11965789</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/17/2019</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**TERRACE COMMUNITIES TEQUESTA ,**

**400 NORTH US ONE  
TEQUESTA, FL 33469**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 085                    | Continued From page 9<br><br>ALF by a qualified trainer.<br><br>The findings included:<br><br>Staff F was interviewed on . . . . . at 10:00 AM<br>and stated he was responsible for the facility's<br>food service and the day-to-day supervision of<br>food service staff. Documentation of a minimum<br>of 2 hours of education completed within the last<br>year in topics pertinent to nutrition and food<br>service in an ALF was requested from the<br>Business Office Manager at this time.<br><br>A certified food manager, licensed dietician,<br>registered dietary technician or health department<br>sanitarian are qualified to train ALF (Assisted<br>Living Facility) Food Service Directors in nutrition<br>and food service. There was no documentation<br>of this training completed by a qualified Trainer<br>dated within the previous year available for review<br>for Staff F. The last training certificate showing<br>completion of this training was dated .<br>The facility provided no additional documentation<br>for review at the time of the survey.<br><br>Class III | A 085               |                                                                                                                          |                          |
| A 091<br>SS=D            | 59A-36.011(12) FAC Training - Documentation &<br>Monitoring<br><br>(12) TRAINING DOCUMENTATION AND<br>MONITORING.<br>(a) Except as otherwise noted, certificates, or<br>copies of certificates, of any training required by<br>this rule must be documented in the facility's<br>personnel files. The documentation must include<br>the following:<br>1. The title of the training program,<br>2. The subject matter of the training program,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | A 091               |                                                                                                                          |                          |

Agency for Health Care Administration

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                          |                          |                                                        |
|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11965789</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/17/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TERRACE COMMUNITIES TEQUESTA,</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>400 NORTH US ONE<br/>TEQUESTA, FL 33469</b>                                  |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 091                                                                    | <p>Continued From page 10</p> <p>3. The training program agenda,<br/>4. The number of hours of the training program,<br/>5. The trainee's name, dates of participation, and<br/>location of the training program,<br/>6. The training provider's name, dated signature<br/>and credentials, and professional license number,<br/>if applicable.</p> <p>(b) Upon successful completion of training<br/>pursuant to this rule, the training provider must<br/>issue a certificate to the trainee as specified in<br/>this rule.</p> <p>(c) The facility must provide the Department of<br/>Elder Affairs and the Agency for Health Care<br/>Administration with training documentation and<br/>training certificates for review, as requested. The<br/>department and agency reserve the right to<br/>attend and monitor all facility in-service training,<br/>which is intended to meet regulatory<br/>requirements.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on record review and an interview, the<br/>facility failed to ensure 2 out of 3 sampled staff<br/>(Staff B and C) had training certificates with all<br/>required components showing the completion of<br/>required in-service training.</p> <p>The findings included:</p> <p>Review of the personnel files for Staff B and C,<br/>who provide direct care to residents, revealed the<br/>following missing or erroneous in-service training<br/>documentation.</p> <p>a. Staff B was hired on . . . . .</p> <p>1. Incident Reporting (part of 1 hour required)<br/>2. Facility's / 's<br/>Policy and Procedure (1 hour)<br/>3. Facility's Elopement Policy and Procedure (no</p> | A 091                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                        |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11965789</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/17/2019</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**TERRACE COMMUNITIES TEQUESTA ,**

**400 NORTH US ONE  
TEQUESTA, FL 33469**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 091                    | Continued From page 11<br><br>minimum time required)<br>4. Neglect and , (part of 1 hour<br>required)<br>5. Safe Food Handling (1 hour)<br><br>b. Staff C was hired on<br><br>1. Facility's Emergency Procedures and Incident<br>Reporting (1 hour)<br>2. Neglect and (part of 1 hour<br>required)<br>3. Facility's / 's<br>Policy and Procedure (1 hour)<br>4. Pre-Service Orientation, 2 hour training<br>certificate, was dated . This training is<br>required to be completed prior to contact with<br>residents. Staff C was hired on .<br><br>The Administrator was notified of these findings<br>at 12:00 PM on . The facility provided no<br>additional documentation of the required training<br>for these staff members at this time.<br><br>Class III | A 091               |                                                                                                                          |                          |
| AE210<br>SS=D            | 59A-36.011(8) FAC ECC - Training<br><br>(8) EXTENDED CONGREGATE CARE (ECC)<br>TRAINING.<br>(a) The administrator and ECC supervisor, if<br>different from the administrator, must complete<br>core training and 4 hours of initial training in<br>extended congregate care prior to the facility<br>receiving its ECC license or within 3 months of<br>beginning employment in a currently licensed<br>ECC facility as an administrator or ECC<br>supervisor. Successful completion of the assisted<br>living facility core training shall be a prerequisite<br>for this training. ECC supervisors who attended                                                                                                                                                  | AE210               |                                                                                                                          |                          |

Agency for Health Care Administration

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                         |                                                                                                                          |                                                        |
|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11965789</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                  |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/17/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TERRACE COMMUNITIES TEQUESTA,</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>400 NORTH US ONE<br/>TEQUESTA, FL 33469</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| AE210                                                                    | <p>Continued From page 12</p> <p>the assisted living facility core training prior to _____, shall not be required to take the assisted living facility core training competency test.</p> <p>(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 _____.</p> <p>(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 requirements, and the delivery of personal care and supportive services in an ECC facility.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and an interview, the facility failed to ensure 2 out of 3 sampled staff (Staff B and C) had completed a minimum of 2 hours of training in Extended Congregate Care (ECC) services within six (6) months of hire.</p> <p>The findings included:</p> <p>Review of the personnel files for Staff B and C, who provide direct care to residents, revealed no documentation of training in ECC services. Staff B was hired on _____. Staff C was hired on _____. This training is required to be completed by direct care staff within six (6) months of hire.</p> <p>The Business Office Manager was asked for documentation of this training on _____ at _____.</p> | AE210                                                                                   |                                                                                                                          |                                                        |

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                        |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11965789</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/17/2019</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**TERRACE COMMUNITIES TEQUESTA ,**

**400 NORTH US ONE  
TEQUESTA, FL 33469**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                            | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| AE210                    | <p>Continued From page 13</p> <p>11:00 AM and was not able to locate it at this time.</p> <p>The Administrator was notified of these findings at 12:00 PM on .... The facility provided no additional documentation of the required training for these staff members at this time.</p> <p>Class III</p> | AE210               |                                                                                                                          |                          |