Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964990	A. BUILDING: _____ B. WING _____	10/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD PARK OF HOLLYWOOD	5770 STIRLING ROAD HOLLYWOOD, FL 33021

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A 000	Initial Comments An unannounced Complaint (#2022014802) survey and a Generator Monitoring survey were conducted from through at Emerald Park of Hollywood. The facility had deficiencies identified related to the Complaint at the time of the survey.	A 000		
A 030	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; . . . . , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close	A 030		

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proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and , ;
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and standard precautions;
8. The requirements for coordinating the delivery of services to residents by third party providers;
9. Assistive devices; and
10. Physical .
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible

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A 030	Continued From page 2 telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the	A 030		

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facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a room with his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care ., and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community.
(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally ., the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care

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A 030	Continued From page 4 Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without [illegible], interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, [illegible], and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder [illegible] Hotline operated by the Department of Children and Families, and, if applicable, [illegible] Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for	A 030		

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A 030	Continued From page 5 exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder [redacted] Hotline operated by the Department of Children and Families, and [redacted], Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated [redacted] or [redacted] under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 4 out of 13 sampled residents (Residents #1, Resident #2, Resident #3 and Resident #4) their right to live in a safe and decent environment. This was evidenced by the facility's failure to implement the necessary interventions to prevent recurring resident to resident physical altercations resulting in resident injuries.	A 030		

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A 030	Continued From page 6 The findings included: Review of the facility's Incident/Accident Report policy and procedure dated in . . , ... included the following requirements: "1. When an accident or an incident takes place, a report should be completed (in full) after the Resident's needs are met. 2. The report is to be made out by the individual(s) having firsthand knowledge of the accident/incident. 3. A clear description of each accident or incident involving danger for the Resident or staff member involved and must include the following: the time, the location the incident occurred, names of all individuals involved, witness if injuries were sustained, nature of injuries, cause of accident, if known, a description of medical or other services provided, who provided the services and steps taken to prevent recurrence". Review of the facility's undated Resident's Rules and Regulations revealed that violence, fighting, behavior or language toward another Resident will not be tolerated, and Residents are to treat other Residents with consideration and respect. Review of the facility's undated Basic Care Services Policy revealed that all Resident care is planned and delivered in a Resident-centered manner and any unusual incident will be reported and documented. Review of Resident #1's Progress Notes dated indicated that the resident was in a	A 030		

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A 030	Continued From page 7 physical altercation with Resident #2, suffered a on her and received first aid by the Director of Nursing (DON). Further review of this record indicated that both residents were separated. Review of Resident #2's Progress Notes dated indicated that the resident was very aggressive and got into a fight with Resident #1. Review of this record indicated that the resident held Resident #1's left and caused a . Review of this record indicated that Resident #2 was told by the nurse to not put on other residents and the consequence will be issuance of a 45-day notice. Review of this record indicated that on , the facility notified Resident #2 that she must vacate the facility and will terminate the resident's contract within 45 days. Review of Resident #3's Progress Notes dated indicated that the resident was found on the floor with a male resident inside her room holding her . Review of this record indicted that on ....., the Activities Director found the resident on the floor due to another resident having pulled the resident out of bed. Review of this record indicated that Caregiver/Medication Technician Staff A notified Resident #3's Hospice Nurse of having found the resident on the floor and the Hospice Nurse notified the resident's family of this event. Review of Resident #3's Hospice Notes dated on ..... indicated that the resident received care to left ..... and also suffered hematoma to left forehead. Further review of the Hospice Notes indicated that the facility staff was unable to "recall" what led to the resident's and being found on the floor.	A 030		

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A 030	Continued From page 8 Review of Resident #4's Progress Notes dated (1:56 PM) indicated that the resident into Resident #3's room and pulled her from the bed, and the resident was found holding Resident #3's , saying he needed a phone. Review of this record dated indicated that the facility contacted Resident #4's representative to inform of resident's behavior and threats to staff. Review of this record dated indicated that Resident #4 pulled Resident #3 from her bed and Resident #3 received a black/blue . Review of this record indicated that Resident #4's family was notified of the resident's behavior concerns and to discuss the need for an increase in medications. Review of this record indicated that on , Resident #4 was given a 45-day notice due to his recent aggressive behavior and the pharmacy was contacted for medication adjustment. In an interview conducted with the Administrator on at 9:10 AM, she stated that she began working in the facility as an Administrator on and since the facility presently did not have a Director of Nursing (DON), she was not updated on all the residents' conditions. She stated that she became aware that Residents #1 and Resident #2 engaged in a physical altercation on and that Resident #2 was the aggressor towards Resident #1. She stated that, to her knowledge, the facility did not presently have any specific interventions in place to prevent future resident on resident altercations, including interactions between Residents #1 and Resident #2. She stated that she did not complete or ask any other staff member to complete any Incident Reports to reflect recent events which affected Residents #1, Resident #2, Resident #3 and Resident #4.	A 030		

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A 030	Continued From page 9 In an interview conducted with Executive Director #1 on at 9:40 AM, she stated that she found out about Residents #1 and Resident #2's physical altercation when the Department of Children and Families (DCF) Investigator visited the facility on to investigate this event. She stated that the previous facility Administrator was not onsite when she spoke with the DCF investigator on . She stated that she did not discuss with the previous Administrator her interaction with the DCF Investigator or any discussions involving the care of Residents #1 and Resident #2, because she was aware that the facility's new Administrator will be on duty on or about . She stated that as a representative for the facility ownership, she was responsible to oversee the transition from the previous Administrator to the new/current Administrator. In an interview conducted with Caregiver/Medication Technician Staff A on at 11:05 AM, she stated that on , at approximately 2:00 PM while in the Memory Care Unit (MCU) hallway, she saw Caregiver Staff B holding Resident #1's with the resident from her . She stated that she immediately accompanied Resident #1 to see the DON in her office. She stated that Resident #1 suffered a to her , approximately 1.5" in size and the DON treated this at that time. She stated that she then went to the MCU on the second floor and Caregiver Staff B told her that Resident #2 caused the on Resident #1's and no other details were provided. She stated that after the DON treated Resident #1's on , she brought the resident to the MCU and kept Resident #1 and Resident #2 separated so to prevent altercations between	A 030		

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these 2 residents. She stated that she did not receive any direction from administration to specifically manage Resident #1 and Resident #2's behaviors, nor was she required to document the event on which resulted in injury to Resident #1.

In an interview conducted with Caregiver Staff B on at 11:30 AM, she stated that after lunch time on , she heard Resident #1 screaming and saw the resident in the MCU hallway walking towards her. She stated that she noticed the resident's left was due to a . She stated that she also noticed Caregiver/Medication Technician Staff A shortly after this in the MCU hallway, and she notified her of what was happening to Resident #1. She stated that Resident #1 told her that Resident #2 did the on her . She stated that Resident #1 and Resident #2 had a history of engaging in verbal arguments for several months, and Resident #2 has verbally threatened Resident #1 before because of how close Resident # sit next to Resident #2 in the dining room. She stated that this behavior was consistent with Resident #2's condition, but the verbal altercations did not rise to any physical until . She stated that she had notified Caregiver/Medication Technician Staff A before of the verbal altercations between these 2 residents, but she was not previously directed by administration to implement interventions to prevent these resident-on-resident altercations. She stated that she was aware that the DON had previously counseled Resident #2 after this event, but the resident continued with the behavior after being counseled. She stated that she did not receive any direction from administration to specifically manage Resident #1 and Resident #2's

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A 030	Continued From page 11 behaviors nor was she required to document the event on , which resulted in injury to Resident #1. In an interview conducted with Caregiver/Medication Technician Staff A on at 11:55 AM, she stated that Caregiver Staff B had notified her before of the verbal altercations between Residents #1 and Resident #2. She stated that these 2 residents had a history of engaging in verbal arguments since and this was consistent with their conditions and the reason why the lived in the MCU. She stated that when she previously notified the DON of events involving Resident #1 and Resident #2, the DON counseled Resident #2 after this behavior. She did not know if the DON's counseling was effective, and she was not aware if any other measures were being done to prevent future aggressive behavior from Resident #2. She stated that she did not know if Resident #2's Physician had recently assessed the resident or if new medications were ordered for the resident. She stated that she spoke with the DON about Resident #2's medical status before the DON resigned from the facility, but she received no directives on this situation. She stated that she was not required to document this event involving Resident #1 and Resident #2 on for each residents' record. She stated that she did not document anything on the residents' record or an Incident Report for this event nor was she asked by administration about the specifics of this event involving Resident #1 and Resident #2 on She stated that another resident who engages in behaviors which may pose a risk to other residents is Resident #4, who had a history of walking around the MCU and into other resident rooms to look for a phone. She stated that Resident #4 has previously walked into	A 030		

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A 030	Continued From page 12 Resident #3's room a few times, uninvited, to look for a phone. She stated that on at approximately 1:00 PM, Caregiver Staff B notified her that Resident #4 went inside Resident #3's room uninvited to look for a phone and the resident pulled Resident #3 out of her bed. She stated that Resident #3 received a to her forehead and since the resident was under hospice services, she notified the Hospice Nurse, and she also notified the Activities Director of this event on She stated that she wrote a brief note on this event in the resident's record, and she was not required to write an Incident Report or any other documentation on this event. In an interview conducted with the Activities Director on at 12:55 PM, she was aware that Resident #1 and Resident #2 engaged in verbal arguments from time to time and that Resident #2 was the one who initiated these arguments. She stated that these verbal arguments had been happening for about 6 months. She stated that she had talked with these residents after they argued, but Resident #2's behavior continued. She stated that these behaviors were consistent with the residents' status and the reason why they lived in the MCU. She stated that Resident #4 also engaged in a behavior pattern which made him to constantly search for a phone to make a call with, despite he did not need to make a call several times during the day. She stated that Resident #4 usually walked around the MCU and into resident rooms looking for a phone and on he did just that. She stated that while she was in the MCU on , Caregiver Staff B notified her that Resident #3 was found on the floor, next to her bed, due to Resident #4 having pulled the resident of her bed. She stated that Caregiver Staff B and her picked Resident #3 up from the	A 030		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 13 floor and placed her . . . on the bed. She stated that on after tending to Resident #3, she notified the Administrator of the event, and she was not directed to complete an Incident Report or to document anything in the resident record due to this event. She stated that she was not required to implement any specific interventions to prevent risky interactions between Resident #3 and Resident #4, but she observed Resident #4 more closely whenever she was in the MCU. She stated that in the morning of . . . . . , she saw Resident #4 going into another resident's room and also into Resident #3's room to look for a phone. She stated that when she saw Resident #4 inside Resident #3's room, the resident kissed Resident #3's and she counseled Resident #4 by telling him to not go into Resident #3's room. She stated that since every single MCU resident is not continually observed at all times, it is possible that Resident # , be able to walk into Resident #3's or other resident's rooms. She stated that the facility had not established any specific interventions to prevent Resident #4 from walking into other resident rooms and specifically Resident #3 who was on hospice due to a condition. In an interview conducted with Resident #3's Hospice Nurse on . . . . . at 1:05 PM, she stated that she was notified that facility staff found Resident #3 on the floor on . . . . . at approximately 2:00 PM. She stated that she responded to the facility the same day at around 3:00 PM and she assessed Resident #3. She stated that the resident sustained a forehead hematoma and a to her left . She stated that the staff reported that Resident #3 was found on the floor on because another resident went inside Resident #3's bedroom and pulled her out of her bed. She	A 030		

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	AL11964990	A. BUILDING: _____ B. WING _____	10/10/2022

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A 030	Continued From page 14 stated that she was not aware if the facility had implemented any specific interventions to prevent future similar events. In an interview conducted on at 1:50 PM with Executive Director #2 who represented the facility ownership, she stated that on , she became aware that Residents #1 and Resident #2 engaged in a physical altercation on and she felt that the general problem in the facility was the lack of communication from the direct care staff all the way up to the Administrator. She stated that she believed that all the staff needed training in overall resident care and procedures. She also became aware on , Resident #4 engaged in behavior which placed Resident #3 at risk, since Resident #3 was found on the floor on and it was believed that Resident #4 was responsible for pulling Resident #3 out of her bed. She stated that when she saw Resident #3 on , she was not injured from this, but the Hospice Nurse was notified regardless. She stated that the direct care staff was asked to pay closer attention to the MCU residents, and this intervention was not formalized or documented. She stated that Resident #4's medications likely needed to be reviewed, but the resident's Physician had not yet assessed the resident after this event. She stated that she also knew that Resident #4 had entered Resident #3's room once again on and Resident #3 was injured from being pulled out of her bed by Resident #4. She stated that the facility did not produce an Incident Report to document this event. Review of Resident #1's record indicated that she was admitted to the facility on and presently lived in the MCU. Review of the resident's most recent Medical Examination dated	A 030		

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A 030	Continued From page 15 on [illegible] indicated that she was diagnosed with [illegible] and [illegible]. This Medical Examination indicated that the resident was alert and disoriented but can follow simple instructions and was a [illegible] and elopement risk. Further review of this Medical Examination indicated that the resident needed assist with ambulation, grooming, toileting and supervision with bathing, [illegible], and needed assist with the self-administration of medications. Review of Resident #2's record indicated that she was admitted to the facility on [illegible] and presently lived in the MCU. Review of the resident's most recent Medical Examination dated on [illegible] indicated that she was diagnosed with [illegible], forgetfulness and was a [illegible] and elopement risk. This Medical Examination indicated that she needed supervision with ambulation, grooming, toileting, bathing, [illegible], eating and assist with transfers and needed assist with the self-administration of medications. Review of Resident #3's record indicated that she was admitted to the facility on [illegible] and presently lived in the MCU with hospice services. Review of the resident's most recent Medical Examination dated on [illegible], she was diagnosed with [illegible], acute failure, [illegible], poor memory, difficulty hearing, [illegible] decline and received hospice services. Review of this Medical Examination indicated that she needed assist with all activities of daily living and needed assist with the self-administration of medications. Review of Resident #4's record indicated that he was admitted to the facility on [illegible] and presently lived in the MCU. Review of the	A 030		

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A 030	Continued From page 16 resident's most recent Medical Examination dated on he was diagnosed with , , agitation and . Review of this Medical Examination indicated that the resident was alert to name only and was a and elopement risk. Review of this Medical Examination indicated that the resident needed supervision with ambulation, grooming, toileting, bathing, , and assist with self-administration of medications. In an interview conducted with the DON on at 9:15 AM, she stated that on , Caregiver/Medication Technician Staff A came to her office and notified her that Resident #1 received a from Resident #2. She stated that it was described to her that Resident #1 sat down in the dining room close to Resident #2 and this triggered Resident #2 to engage in a verbal argument with Resident #1 and this led to Resident #2 forcefully grabbing Resident #1's and causing a . She stated that Resident #1 had very thin skin and it was susceptible to mechanical injury like this. She stated that on , she went to speak to Resident #2, and the resident admitted to having forcefully grabbed Resident #1 by her and agreed not to do this again. She stated that she told Resident #2 that the facility will issue her a 45-day notice for relocation and that the facility did not immediately issue a 45-day notice to the Resident. She stated that on , she notified the involved resident family members and the Administrator of this event. She stated that she wrote an Incident Report regarding this event, which she gave to the previous Administrator before she resigned from the facility the first week of , . She stated that she also was aware that Resident #2's Nurse Practitioner was notified of the resident's	A 030		

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A 030	Continued From page 17	A 030		

outbursts, but she did not know the outcome of the medical assessment or subsequent orders. She stated that this was the only time she was aware of Resident #1 and Resident #2 being in an altercation, and she recommended for these 2 residents to not sit by each other in close proximity. She stated that she was not aware if the facility had implemented any specific interventions to prevent future similar events.

In an interview conducted with Resident #3's representative on at 1:55 PM, she stated that on or about . . . . . she was notified by the Administrator that Resident #3 was found on the floor next to her bed, and that she did not know how this happened. She stated that the Administrator reported that the resident was not injured, and she advised the Administrator that she did not want this to happen again. She stated that this was concerning since Resident #3 lived in the facility with hospice care for a . . condition, was bedridden, and very . . . . . She stated that she was notified by the Hospice Nurse on that Resident #3 was found on the floor that day and was injured with a bump on her and a . She stated that she called the Administrator immediately after receiving this report from the Hospice Nurse and the Administrator confirmed this. She stated that the Administrator told her that another resident went inside Resident #3's room to look for a phone and likely pulled her out of the bed. The Administrator also told her that the facility was going through some staffing issues and was in process to move the resident who caused this to Resident #3, out of the facility. She stated that she felt this was preventable and that not maintaining close supervision of Resident #3 and other residents in the MCU was neglectful. She stated that she was not told that

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A 030	Continued From page 18 the facility was implementing any other interventions to prevent future similar events In an interview conducted with Resident #4's representative on at 1:50 PM, she stated that the Administrator notified her a few weeks ago that Resident #4 was trying "to touch another Resident" and since she was out of the country, she had not given it much attention. She stated that she was initiating the process to move Resident #4 out of the facility, but she had no definitive information at that time. Review of Resident #4's record indicated that on at 10:00 AM, the resident received an involuntary Medical Examination due to being diagnosed with , , and having refused a voluntary examination. Further review of this involuntary Medical Examination indicated that the resident was , had poor impulse control and insight, and was likely to cause serious bodily harm to himself without care and treatment from a receiving facility. Review of Resident #1, Resident #2 and Resident #3's records revealed that there were no other recent Medical Evaluations done to assess each resident's behaviors and status. Review of these resident records indicated that there were no documented interventions or orders from treating Physicians for implementation by the facility to prevent further physical altercations and associated behaviors from these residents. Further review of the facility records indicated that there were no completed Incident Reports to reflect the recent physical altercations between Resident #1 and Resident #2 and Resident #3 and Resident #4. Class II	A 030		

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A 077	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter.	A 077		

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A 077	Continued From page 20 (a) An administrator must: 1. Be at least [illegible]; 2. If employed on or after [illegible], have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to [illegible], are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the [illegible] of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of	A 077		

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A 077	Continued From page 21 either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility Administrators failed to adequately operate the	A 077		

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A 077	Continued From page 22 facility by not supervising and managing the direct care staff members to ensure appropriate care to its facility residents. The findings included: Review of the facility's Incident/Accident Report Policy and Procedure dated on , included the following requirements: "1. When an accident or an incident takes place, a report should be completed (in full) after the resident's needs are met. 2. The report is to be made out by the individual(s) having firsthand knowledge of the accident/incident. 3. A clear description of each accident or incident involving danger for the resident or staff member involved and must include the following: the time, the location the incident occurred, names of all individuals involved, witness if injuries were sustained, nature of injuries, cause of accident, if known, a description of medical or other services provided, who provided the services and steps taken to prevent recurrence". Review of the facility's undated Basic Care Services Policy revealed that all resident care is planned and delivered in a resident-centered manner and any unusual incident will be reported and documented. In an interview conducted with the Administrator on at 9:10 AM, she stated that she began working in the facility as an Administrator on and since the facility presently did not have a Director of Nursing (DON), she was not updated on all the residents' conditions and	A 077		

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A 077	Continued From page 23 specific resident-centered services they needed. She stated that she did not know when the previous Administrator resigned or left her position here at the facility. In an interview conducted with Executive Director #1 on [redacted] at 9:40 AM, she stated that she learned on [redacted] that on [redacted], Resident #2 was physically aggressive towards Resident #1 and this led to Resident #1 being injured with a [redacted] to her [redacted]. She stated that as a representative for the facility ownership, she was responsible to oversee the transition from the previous Administrator to the new/current Administrator who came onboard on [redacted]. She stated that she did not inquire about the event involving Resident #1 and Resident #2 to the previous Administrator and she did not know the date of when the previous Administrator resigned or left her position at the facility. In an interview conducted with Executive Director #2 on [redacted] at 1:50 PM, who represents the facility ownership, she stated that when she was employed by the facility ownership on [redacted], she learned that Resident #1 and Resident #2 engaged in a physical altercation on [redacted] and she felt that the general problem in the facility was the lack of communication from the direct care staff all the way up to the Administrator. She stated that she believed that all the staff needed training in overall resident care and procedures. She also became aware on [redacted], that Resident #4 engaged in behavior which placed Resident #3 at risk. She stated that she also knew that Resident #4 had entered Resident #3's room once again on [redacted] and Resident #3 was injured from being pulled out of her bed by Resident #4. She stated that since the facility Administrator was hired on [redacted], the facility	A 077		

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A 077	Continued From page 24 has not had the opportunity to develop adequate systems to manage and supervise the staff to ensure optimal resident care and follow all of its policies and procedures. She stated that the facility has not yet provided any staff training in response to the identified resident behaviors which may place other residents at risk, during this transition of Administrators. In an interview conducted with the Administrator on at 3:30 PM, she had not ensured that every direct care staff member were following all of the facility's policies and procedures including documenting every Incident Report which reflected the delivery of resident-centered care. Review of an email dated on from Executive Director #2, she stated that the previous Administrator's last day of employment at the facility was on and that the new Administrator started her employment on . Review of this email indicated that the facility did not have an onsite Administrator responsible for the operation of the facility from until when the new Administrator began working at the facility. Class III	A 077		
A 081	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in	A 081		

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A 081	Continued From page 25 duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility.	A 081		

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A 081	Continued From page 26 (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in . . . . control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its . . . . control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident . . . . , neglect, and , . The facility must use its . . . . prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095,	A 081		

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	AL11964990	A. BUILDING: _____ B. WING _____	10/10/2022

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A 081	Continued From page 27 F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to represent completion of the required training for 6 out of 10 sampled staff members (Staff A, C, D, E, F and H) by not keeping certification of completion of inservice training in each of the employee's personnel records. The findings included: Review of Staff A's personnel record indicated that the staff member was initially hired on and presently worked in the facility as a direct care staff member. Review of this	A 081		

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A 081	Continued From page 28 personnel record indicated that the staff member's responsibilities and duties included to observe and assess the physical and safety needs of residents, report accidents/incidents when they occur, report changes applicable to residents' conditions and keep current on training regulations. Further review of this personnel record revealed that there was no signed statement from the staff member and the Administrator to represent completion of inservice training that covered resident rights and the recognition and reporting of , neglect and , which must use the facility's own prevention policies and procedures. (Photographic evidence was obtained.) Review of Staff C's personnel record indicated that the staff member was initially hired on and presently worked in the facility as a direct care staff member. Review of this personnel record indicated that the staff member's responsibilities and duties included to observe and assess the physical and safety needs of residents, report accidents/incidents when they occur, report changes applicable to residents' conditions and keep current on training regulations. Further review of this personnel record revealed that there was no signed statement from the staff member and the Administrator to represent completion of inservice training that covered resident rights and the recognition and reporting of , neglect and , which must use the facility's own prevention policies and procedures. Review of Staff D's personnel record indicated that the staff member was initially hired on and presently worked in the facility as a direct care staff member. Review of this personnel record indicated that the staff	A 081		

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A 081	Continued From page 29	A 081		

member's responsibilities and duties included to observe and assess the physical and safety needs of residents, report accidents/incidents when they occur, report changes applicable to residents' conditions and keep current on training regulations. Further review of this personnel record revealed that there was no signed statement from the staff member and the Administrator to represent completion of inservice training that covered the recognition and reporting of , neglect and , which must use the facility's own prevention policies and procedures.

Review of Staff E's personnel record indicated that the staff member was initially hired on and presently worked in the facility as a direct care staff member. Review of this personnel record indicated that the staff member's responsibilities and duties included to observe and assess the physical and safety needs of residents, report accidents/incidents when they occur, report changes applicable to residents' conditions and keep current on training regulations. Further review of this personnel record revealed that there was no signed statement from the staff member and the Administrator to represent completion of inservice training that covered resident rights and the recognition and reporting of , neglect and , which must use the facility's own prevention policies and procedures.

Review of Staff F's personnel record indicated that the staff member was initially hired on and presently worked in the facility as a direct care staff member. Review of this personnel record indicated that the staff member's responsibilities and duties included to observe and assess the physical and safety

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A 081	Continued From page 30 needs of residents, report accidents/incidents when they occur, report changes applicable to residents' conditions and keep current on training regulations. Further review of this personnel record revealed that there was no signed statement from the staff member and the Administrator to represent completion of inservice training that covered resident rights and the recognition and reporting of . . . . . , neglect and . , which must use the facility's own . . . . . prevention policies and procedures. Review of Staff H's personnel record indicated that the staff member was initially hired on . . . . . and presently worked in the facility as a direct care staff member. Review of this personnel record indicated that the staff member's responsibilities and duties included to observe and assess the physical and safety needs of residents, report accidents/incidents when they occur, report changes applicable to residents' conditions and keep current on training regulations. Further review of this personnel record revealed that there was no signed statement from the staff member and the Administrator to represent completion of inservice training that covered resident rights and the recognition and reporting of . . . . , neglect and . . . . . , which must use the facility's own . . prevention policies and procedures. In an interview conducted with the Administrator on . . . . . at 12:45 PM, she stated that she did not know that the personnel records provided for review did not have all the required certifications to represent completed training for each staff member. Class III	A 081		

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A 086	Continued From page 31	A 086		
A 086	59A-36.011(10) FAC Training - ADRD (10) [illegible] AND RELATED [illegible] ("ADRD") TRAINING REQUIREMENTS. Facilities which advertise that they provide special care for persons with ADRD, or who maintain secured areas as described in Chapter 4, Section 464.4.6 of the Florida Building Code, as adopted in rule 61G20-1.001, F.A.C., Florida Building Code Adopted, must ensure that facility staff receive the following training. (a) Facility staff who interact on a daily basis with residents with ADRD but do not provide direct care to such residents and staff who provide direct care to residents with ADRD, shall obtain 4 hours of initial training within 3 months of employment. Completion of the core training program between [illegible] and [illegible] shall satisfy this requirement. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. Initial training, entitled "[illegible] and Related Level I Training," must address the following subject areas: 1. Understanding [illegible]'s and related [illegible]; 2. Characteristics of [illegible]; 3. Communicating with residents with [illegible]'s [illegible]; 4. Family issues; 5. Resident environment; and, 6. Ethical issues. (b) Staff who have successfully completed both the initial one hour and continuing three hours of ADRD training pursuant to sections 400.1755, 429.917 and 400.6045(1), F.S., shall be considered to have met the initial assisted living facility [illegible] and Related	A 086		

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A 086	Continued From page 32 . . . . . Level I Training. (c) Facility staff who provide direct care to residents with ADRD must obtain an additional 4 hours of training, entitled " and Related . . . . . Level II Training," within 9 months of employment. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. and Related . Level II Training must address the following subject areas as they apply to these . : 1. Behavior management, 2. Assistance with ADLs, 3. Activities for residents, 4. Stress management for the care giver; and, 5. Medical information. (d) A detailed description of the subject areas that must be included in an ADRD curriculum which meets the requirements of paragraphs (a) and (b) of this subsection, can be found in the document "Training Guidelines for the Special Care of Persons with . . . 's . . . . . and Related ," dated , incorporated by reference, available from the Department of Elder Affairs, 4040 Esplanade Way, Tallahassee, Florida 32399-7000. (e) Direct care staff shall participate in 4 hours of continuing education annually as required under section 429.178, F.S. Continuing education received under this paragraph may be used to meet 3 of the 12 hours of continuing education required by section 429.52, F.S., and subsection (1) of this rule, or 3 of the 6 hours of continuing education for extended congregate care required by subsection (7) of this rule. (f) Facility staff who have only incidental contact with residents with ADRD must receive general written information provided by the facility on	A 086		

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A 086	Continued From page 33 interacting with such residents, as required under section 429.178, F.S., within three (3) months of employment. "Incidental contact" means all staff who neither provide direct care nor are in regular contact with such residents. (g) Persons who seek to provide ADRD training in accordance with this subsection must provide the department or its designee with documentation that they hold a Bachelor's degree from an accredited college or university or hold a license as a registered nurse, and: 1. Have 1 year teaching experience as an educator of caregivers for persons with or related , or 2. Three years of practical experience in a program providing care to persons with or related , or 3. Completed a specialized training program in the subject matter of this program and have a minimum of two years of practical experience in a program providing care to persons with or related . (h) With reference to requirements in paragraph (g), a Master's degree from an accredited college or university in a subject related to the content of this training program can substitute for the teaching experience. Years of teaching experience related to the subject matter of this training program may substitute on a year-by-year basis for the required Bachelor's degree referenced in paragraph (g). This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that 2 out of 10 sampled staff members (Staff C and Staff H) received and Related (ADRD) training comprised of an initial 4-hour ADRD Level I and an additional 4-hour ADRD Level II course.	A 086		

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A 086	Continued From page 34 The findings included: Review of Staff C's personnel record indicated that the staff member was initially hired on and presently worked in the facility as a direct care staff member who provided services to ADRD residents. Review of the staff member's personnel record revealed that there was no certificate to represent completion of an ADRD Level I or Level II training. Review of Staff H's personnel record indicated that the staff member was initially hired on and presently worked in the facility as a direct care staff member who provided services to ADRD residents. Review of the staff member's personnel record revealed that there was no certificate to represent completion of an ADRD Level I or Level II training. (Photographic evidence was obtained). In an interview conducted with the Administrator on at 12:45 PM, she stated that she did not know that the personnel records provided for review did not have all the required certifications to represent completed training for each staff member. Class III	A 086		