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
	AL11953318	A. BUILDING: _____ B. WING _____	R-C 03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEANETTE BOSTON ALF	6916 N. 30TH STREET TAMPA, FL 33610

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

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{A 078}	Continued From page 1 observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility . . . . . to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain a one-time statement that the employee was free from signs and symptoms of communicable from a health care provider and evidence of a negative . . . . . ( ) examination for one employee (Staff D) of six sampled employees. Findings Included: A review of Staff D's employee record, conducted on , revealed that Staff D's record did not have a one-time statement that the employee was free from signs and symptoms of	{A 078}		

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{A 078}	Continued From page 2 communicable . . . . . from a health care provider. Staff D's record did not contain evidence of a negative . examination. There was no date of hire noted in Staff D's employee record. During an interview with the Administrator, conducted on . . . . . at 11:10am, the Administrator was unable to provide evidence that Staff D had a negative . examination or a one-time statement that the employee was free from communicable . . . . . from a health care provider. Class III	{A 078}		
{A 079} SS=D	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 212 16-25 253 26-35 294 36-45 335 46-55 375 56-65 416 66-75 457 76-85 498 86-95 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in	{A 079}		

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{A 079}	Continued From page 3 subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and [illegible] ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least [illegible] must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a	{A 079}		

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{A 079}	Continued From page 4 calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision	{A 079}		

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{A 079}	Continued From page 5 and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020,	{A 079}		

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{A 079}	Continued From page 6 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to have a staff schedule that reflected its twenty-four-hour staffing pattern. Furthermore, the facility failed to have at least one staff member that had access to facility, staff, and resident records in the event of an emergency. Findings Included: During an observation, conducted on [redacted] at 09:10am, Staff A (Medication Technician/Resident Care Aide) was arriving at the facility. Staff B (Medication Technician/Resident Care Aide) had left her duties prior to Staff A arriving. There was no staff on duty for an undetermined amount of time prior to Staff A's arrival. The Administrator arrived at 09:45pm and provided the requested documents. The Administrator left the facility at 12:37pm and had not returned by the end of survey at 03:45pm. During an attempt to review facility, resident, and employee records from Staff A, conducted on [redacted] at 09:15am, Staff A did not provide the facility, resident, and employee records. After requesting records again at 09:22am, Staff A stated that Staff B must have left the facility to catch the bus. Staff A stated that she did not have access to facility, employee, and resident records and that the Administrator was on her way to the facility. Staff A stated that herself and Staff B were the only staff that worked in the facility. Staff A stated that the Administrator and the Fiscal Agent only work when either she or Staff B do not feel	{A 079}		

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{A 079}	Continued From page 7 well. Staff A stated that she works from 09:00am through 05:00pm Monday through Thursday and comes at 05:00pm on Saturday and works through 05:00pm on Monday and then Staff B takes over. A review of the staffing schedule for Wednesday, conducted on , revealed that the staffing schedule did not accurately reflect the facility's twenty-four hours staffing pattern. The staffing schedule did not have employees' names but only their first and last name initials. There was no employee identified with the same initials as Staff G. The staffing schedule was noted as: Administrator - Monday 02:00p - 10:00pm - Tuesday 02:00p - 10:00pm - Wednesday 02:00p - 10:00pm Fiscal Agent - Thursday 02:00p - 10:00pm - Friday 02:00p - 10:00pm - Saturday 02:00pm - Sunday at 09:00am Staff A - Sunday 09:00am - 06:00pm and 10:00pm - 09:00am Monday - Monday 08:00am - 06:00pm - Tuesday 08:00am - 06:00pm - Wednesday 08:00am - 06:00pm - Thursday 08:00am - 06:00pm Staff B - Monday 10:00pm - 09:00am - Tuesday 10:00pm - 09:00am - Wednesday 10:00pm - 09:00am - Thursday 10:00pm - 09:00am - Friday 10:00pm - 09:00am Staff G - Sunday 02:00p - 10:00pm - Friday 08:00am - 06:00pm - Saturday 09:00am - 06:00pm	{A 079}		

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{A 079}	Continued From page 8 During an interview with the Administrator, conducted on [redacted] at 09:45am, the Administrator stated that the Fiscal Agent was in another State. During a telephone interview with the Fiscal Agent, conducted on [redacted] from 03:00pm - 03:26pm, the Fiscal Agent stated that he had been in another State for four days and has a job in the other State and would not be at the facility. The Fiscal Agent stated that Staff B should not have left before Staff A arrived. The Fiscal Agent agreed that the staffing schedule was not reflective of the facility staffing pattern. Class III	{A 079}		
{A 080} SS=D	429.52([redacted]) FS; 59A-36.011(1) FAC Training - Core & Competency Test 429.52 (2) Administrators and other assisted living facility staff must meet minimum training and education requirements established by the agency by rule. This training and education is intended to assist facilities to appropriately respond to the needs of residents, to maintain resident care and facility standards, and to meet licensure requirements. (3) The agency, in conjunction with providers, shall develop core training requirements for administrators consisting of core training learning objectives, a competency test, and a minimum required score to indicate successful passage of the core competency test. The required core competency test must cover at least the following topics: (a) State law and rules relating to assisted living facilities.	{A 080}		

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{A 080}	Continued From page 9 (b) Resident rights and identifying and reporting , neglect, and , . (c) Special needs of elderly persons, persons with mental illness, and persons with , and how to meet those needs. (d) Nutrition and food service, including acceptable sanitation practices for preparing, storing, and serving food. (e) Medication management, recordkeeping, and proper techniques for assisting residents with self-administered medication. (f) Firesafety requirements, including fire evacuation drill procedures and other emergency procedures. (g) Care of persons with 's and related . 59A-36.011 (1) ASSISTED LIVING FACILITY CORE TRAINING REQUIREMENTS AND COMPETENCY TEST. (a) The assisted living facility core training requirements established by the department pursuant to section 429.52, F.S., shall consist of a minimum of 26 hours of training plus a competency test. (b) Administrators and managers must successfully complete the assisted living facility core training requirements within 3 months from the date of becoming a facility administrator or manager. Successful completion of the core training requirements includes passing the competency test. The minimum passing score for the competency test is 75%. Administrators who have attended core training prior to , , , and managers who attended the core training program prior to , , , shall not be required to take the competency test. Administrators licensed as nursing home	{A 080}		

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{A 080}	Continued From page 10 administrators in accordance with chapter 468, part II, F.S., are exempt from this requirement. (c) Administrators and managers shall participate in 12 hours of continuing education in topics related to assisted living every 2 years. (d) A newly hired administrator or manager who has successfully completed the assisted living facility core training and continuing education requirements, shall not be required to retake the core training. An administrator or manager who has successfully completed the core training but has not maintained the continuing education requirements will be considered a new administrator or manager for the purposes of the core training requirements and must: 1. Retake the assisted living facility core training; and, 2. Retake and pass the competency test. (e) The fees for the competency test shall not exceed $200.00. The payment for the competency test fee shall be remitted to the entity administering the test. A new fee is due each time the test is taken. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide evidence that the Administrator satisfied a minimum of twelve continuing education every two years for assisted living facility core training requirements. Findings Included: An employee record review for the Administrator, conducted on [redacted], revealed that the Administrator did not have evidence that of obtaining twelve hours of continuing education credits every two years for assisted living facility	{A 080}		

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{A 080}	Continued From page 11 core training requirements since obtaining assisted living core training on . During an interview with the Administrator, conducted on at 11:20, the Administrator was unable to provide evidence that the she had completed twelve hours of continuing education every two years since obtaining core training on . Class III	{A 080}		
{A 081} SS=D	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 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.	{A 081}		

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{A 081}	Continued From page 12 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. (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.	{A 081}		

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{A 081}	Continued From page 13 (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident . . . . . , neglect, and , . The facility must use its . . prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (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.	{A 081}		

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	AL11953318	A. BUILDING: _____ B. WING _____	R-C 03/29/2023

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{A 081}	Continued From page 14 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 provide direct care staff with the required in-service training for five employees (Fiscal Agent, Staff A, Staff B, Staff D and Staff E) of five sampled employees. Findings Included: An employee record review for the Fiscal Agent, conducted on . . . . . , revealed that the Fiscal Agent's employee record did not contain evidence that the employee had training regarding activities of daily living and behavioral needs, adverse incident reporting, and resident rights and recognizing and reporting neglect, and . . , ... trainings within thirty days of hire. The Fiscal Agent was hired on . . . . . . A review of the staffing schedule, conducted on , revealed that the Fiscal Agent was scheduled to work alone in the facility and provide direct every Thursday and Friday from 02:00pm to 10:00pm and every Saturday from 02:00pm to Sunday at 09:00am. An employee record review for Staff A, conducted on . . . . . , revealed that Staff A's employee record did not contain evidence that the employee had training regarding adverse incident reporting and resident rights and recognizing and reporting	{A 081}		

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{A 081}	Continued From page 15 , neglect, and , trainings within thirty days of hire. Staff A was hired on . An employee record review for Staff B, conducted on , revealed that Staff B's employee record did not contain evidence that the employee had training regarding activities of daily living and behavioral needs, adverse incident reporting, and resident rights and recognizing and reporting , neglect, and , trainings within thirty days of hire. Staff B was hired on . An employee record review for Staff D, conducted on , revealed that Staff D's employee record did not contain evidence that the employee training regarding a two-hour pre-service orientation and control prior to direct care. Staff D's employee record did not contain evidence that the employee had trainings regarding activities of daily living and behavioral needs, adverse incident reporting, emergency procedures, nutrition and safe food handling, elopement response, and resident rights and recognizing and reporting , neglect, and , trainings within thirty days of hire. Staff D's date of hire was not in the employee's record. A review of the complaint investigation, conducted on , revealed that Staff D was working at the facility. An employee record review for Staff E, conducted on , revealed that Staff E's employee record did not contain evidence that the employee training regarding a two-hour pre-service orientation and control prior to direct care.	{A 081}		

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{A 081}	Continued From page 16 During an interview with the Administrator, conducted on [redacted] at 11:15am, the Administrator was unable to provide evidence that the Fiscal Agent, Staff A, Staff B, Staff D, and Staff E obtained all the required in-service training. At 12:19pm, the Administrator did not provide Staff E's date of hire and stated that Staff E was hired last week. Class III	{A 081}		
A 082 SS=D	59A-36.011(4) FAC Training - [redacted] (4) [redacted]. Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on and , including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that employees had the required one-time education course on [redacted] for one employee (Staff D) of five sampled employees. Findings Included: A review of Staff D's employee record, conducted	A 082		

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A 082	Continued From page 17 on . . . . . , revealed that Staff D's record did not have a one-time statement education course on / . . . There was no date of hire noted in Staff D's employee record. During an interview with the Administrator, conducted on . . . . . at 11:10am, the Administrator was unable to provide evidence that Staff D obtained a one-time education course on / . The Administrator did not provide Staff D's date of hire. Class III	A 082		
A 090 SS=D	59A-36.011(11) FAC Training - . . . (11) . . TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding . (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding . . within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have evidence that employees received a one-hour training for . . . . . ( ) for four employees (Administrator, Fiscal Agent, and Staff A and B) of four sampled	A 090		

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A 090	Continued From page 18 employees. Findings Included: A review of the training dated for the Administrator, Fiscal Agent, and Staff A and B, conducted on , revealed that the training included the facility procedures as follows: 1. Call 911 for medical assistance 2. Check resident for breathing, rate 3. Communicate with resident to test their awareness 4. Call Administrator and relative or guardian of record 5. Check resident book for 6. Advised emergency crew of when they arrive 7. If resident is in a share room, remove the roommate until incident is resolved 8. Check other residents while emergency crew performs their review 9. Record incident in progress notes and resident books 10. Review sample of (see attached) The training was not representative of one hour's worth of training. The only attachment to the training procedures was the employee signature page signed by the Administrator, Fiscal Agent, and Staff A and B on . During an interview with the Administrator, conducted on at 12:19pm, the Administrator agreed that the training was not representative of one hour's worth of training. The Administrator was unable to provide evidence of adequate training.	A 090		

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A 090	Continued From page 19 Class III	A 090		
{CZ841} SS=D	408.823( ) FS In-person Visitation (1) This section applies to [redacted] centers as defined in s. 393.063, hospitals licensed under chapter 395, nursing home facilities licensed under part II of chapter 400, hospice facilities licensed under part of chapter 400, intermediate care facilities for the [redacted] licensed and certified under part VIII of chapter 400, and assisted living facilities licensed under part I of chapter 429. (2)(a) No later than 30 days after the effective date of this act, each provider shall establish visitation policies and procedures. The policies and procedures must, at a minimum, include [redacted] control and education policies for visitors; screening, personal protective equipment, and other [redacted] control protocols for visitors; permissible length of visits and numbers of visitors, which must meet or exceed the standards in ss. 400.022(1)(b) and 429.28(1)(d), as applicable; and designation of a person responsible for ensuring that staff adhere to the policies and procedures. Safety-related policies and procedures may not be more stringent than those established for the provider's staff and may not require visitors to submit proof of any [redacted] or immunization. The policies and procedures must allow consensual physical contact between a resident, client, or patient and the visitor. (b) A resident, client, or patient may designate a visitor who is a family member, friend, guardian, or other individual as an essential caregiver. The provider must allow in-person visitation by the essential caregiver for at least 2 hours daily in	{CZ841}		

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{CZ841}	Continued From page 20	{CZ841}		

addition to any other visitation authorized by the provider. This section does not require an essential caregiver to provide necessary care to a resident, client, or patient of a provider, and providers may not require an essential caregiver to provide such care.
(c) The visitation policies and procedures required by this section must allow in-person visitation in all of the following circumstances, unless the resident, client, or patient objects:
1. End-of-life situations.
2. A resident, client, or patient who was living with family before being admitted to the provider ' s care is struggling with the change in environment and lack of in-person family support.
3. The resident, client, or patient is making one or more major medical decisions.
4. A resident, client, or patient is experiencing emotional distress or grieving the loss of a friend or family member who recently .
5. A resident, client, or patient needs cueing or encouragement to eat or drink which was previously provided by a family member or caregiver.
6. A resident, client, or patient who used to talk and interact with others is seldom speaking.
7. For hospitals, childbirth, including labor and delivery.
8. patients.
(d) The policies and procedures may require a visitor to agree in writing to follow the provider's policies and procedures. A provider may suspend in-person visitation of a specific visitor if the visitor violates the provider's policies and procedures.
(e) The providers shall provide their visitation policies and procedures to the agency when applying for initial licensure, licensure renewal, or change of ownership. The provider must make

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{CZ841}	Continued From page 21 the visitation policies and procedures available to the agency for review at any time, upon request. (f) Within 24 hours after establishing the policies and procedures required under this section, providers must make such policies and procedures easily accessible from the homepage of their websites. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have a visitation policy and procedures within thirty days of . . . . . that included control and education policies related to screening, personal protective equipment, permissible length and number of visitors, consensual physical contact between visitors, essential caregiver visits, and a designation of a person responsible for ensuring that staff adhere to the policies and procedures. Furthermore, the facility failed to have a visitation policy and procedures posted on the facility website. Findings Included: A review the facility's visitation policy and procedures, conducted on . . . . . , the updated visitation policy stated that: The facility hours of is 24/7 every day. The hours for visitation for family members and others is from 10am to 7pm of every day. We ask family members to call in ahead of time to me with their love ones. Third Party Health Providers are ask to schedule their attendance from 9am to 7pm. The visitation policy and procedures did not include control and education policies related to screening, personal protective equipment, permissible length and number of	{CZ841}		

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{CZ841}	Continued From page 22 visitors, consensual physical contact between visitors, essential caregiver visits, and a designation of a person responsible for ensuring that staff adhere to the policies and procedures. The visitation policy and procedures did not include the allowance of in-person visits for visits under the following circumstances: End-of-life situations A resident, client, or patient who was living with family before being admitted to the provider's care is struggling with the change in environment and lack of in-person family support The resident, client, or patient is making one or more major medical decisions A resident, client, or patient is experiencing emotional distress or grieving the loss of a friend or family member who recently . . . A resident, client, or patient needs cueing or encouragement to eat or drink which was previously provided by a family member or caregiver A resident, client, or patient who used to talk and interact with others is seldom speaking. The length of the visits and numbers of visitors which allow for consensual physical contact between residents and the visitors The . . . . . control and education policies for visitors for screening, personal protective equipment, and other . . . . control protocols for visitors The designation of a person responsible for	{CZ841}		

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{CZ841}	Continued From page 23 ensuring that staff adhere to the policies and procedures A review of the facility's website Jeanette Boston Alf Inc - Assisted Living Facility in Tampa (business.site), conducted on , revealed that there was no visitation policy and procedures posted to the website. During an interview with the Administrator, conducted on . . . . . at 11:45am, the Administrator agreed that the facility's visitation policy and procedures did not include all of the required information and that it was not posted to the facility's website. Class III	{CZ841}		
{A 091} SS=D	59A-36.011(12) FAC Training - Documentation & Monitoring (12) TRAINING DOCUMENTATION AND MONITORING. (a) Except as otherwise noted, certificates, or copies of certificates, of any training required by this rule must be documented in the facility's personnel files. The documentation must include the following: 1. The title of the training program, 2. The subject matter of the training program, 3. The training program agenda, 4. The number of hours of the training program, 5. The trainee's name, dates of participation, and location of the training program, 6. The training provider's name, dated signature and credentials, and professional license number, if applicable.	{A 091}		

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{A 091}	Continued From page 24 (b) Upon successful completion of training pursuant to this rule, the training provider must issue a certificate to the trainee as specified in this rule. (c) The facility must provide the Department of Elder Affairs and the Agency for Health Care Administration with training documentation and training certificates for review, as requested. The department and agency reserve the right to attend and monitor all facility in-service training, which is intended to meet regulatory requirements. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have training certificates with the subject matter of the training program, the training program agenda, the number of hours of the training program, the location of the training program, and the training provider's name, dated signature, and credentials for four employees (Fiscal Agent and Staff A and B) of four sampled employees. Findings Included: A review of the training certificate dated for the Administrator, Fiscal Agent, and Staff A and B, conducted on , revealed that there was one training certificate for the employees. The training certificate did not include the subject matter of the training program, the training program agenda, the number of hours of the training program, the location of the training program, and the training provider's name, dated signature, and credentials. During an interview with the Administrator, conducted on at 12:19pm, the	{A 091}		

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{A 091}	Continued From page 25 Administrator agreed that the training training certificate did not include the subject matter of the training program, the training program agenda, the number of hours of the training program, the location of the training program, and the training provider's name, dated signature, and credentials. Class III	{A 091}		
{A 160} SS=D	59A-36.015(1) FAC Records - Facility The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a	{A 160}		

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{A 160}	Continued From page 26 resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . . . . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with . . . . 's . . . . or related . . . . . , a copy of all such facility advertisements as required by section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in rule 59A-36.007, F.A.C. (j) All food service records required in rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the	{A 160}		

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{A 160}	Continued From page 27 local authority or the State Fire Marshal pursuant to section 429.41, F.S., and rule chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to section 381.031, F.S., and chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain an admission and discharge log that included residents' dates and places of admission and reasons and places of discharge for four current Residents (#2, #4, #5, and #6) and two discharged Residents (#7 and #8) of six sampled current and former residents. Findings Included: A review of the admission and discharge log, conducted on , revealed that the admission and discharge log did not include current Residents #2, #4, #5, and #6's dates of admission. The admission and discharge log did not include Resident #7's reason or place of	{A 160}		

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	AL11953318	A. BUILDING: _____ B. WING _____	R-C 03/29/2023

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{A 160}	Continued From page 28 discharge. The admission and discharge log did not include former Resident #8's date and place of admission and reason for discharge. During an interview with the Fiscal Agent, conducted on at 03:05pm, the Fiscal Agent agreed that the admission and discharge log did not include current Residents #2, #4, #5, and #6's dates of admission. The Fiscal Agent agreed that the admission and discharge log did not include Resident #7's reason or place of discharge. The Fiscal Agent agreed that the admission and discharge log did not include former Resident #8's date and place of admission and reason for discharge. Class III	{A 160}		
{A 165} SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in:	{A 165}		

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{A 165}	Continued From page 29 1. [illegible]; 2. [illegible] or [illegible] damage; 3. Permanent [illegible]; 4. [illegible] or [illegible] of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) [illegible], neglect, or [illegible] must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459,	{A 165}		

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{A 165}	Continued From page 30 chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to submit adverse incident reports to the Agency for one Resident (#3) of one sampled resident that eloped from the facility on two occasions. Findings Included:	{A 165}		

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{A 165}	Continued From page 31 During a review of the complaint investigation, conducted on . . . . . , revealed that Resident #3 had eloped on . . . . and on . . . . . . During an attempt to review adverse incident reports submitted to the Agency for Resident #3, conducted on . . . . . , revealed that there were no adverse incident reports to review. During an interview with the Fiscal Agent, conducted on . . . . . at 03:10pm, the Fiscal Agent stated that the facility had not submitted an adverse incident report to the Agency regarding Resident 3's elopements on . or . . . . . . Class III	{A 165}		
{A 170} SS=D	429.24(3)a Resident Refund Policy ....The facility shall provide a refund to the resident or responsible party within 45 days after the transfer, discharge, or . . . of the resident. The agency shall impose a fine upon a facility that fails to comply with the refund provisions of the paragraph, which fine shall be equal to three times the amount due to the resident. One-half of the fine shall be remitted to the resident or his or her estate, and the other half to the Health Care Trust Fund to be used for the purpose specified in s. 429.18. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide a refund within 45-days of transfer for one Resident (#8) of one sampled resident that discharged to a higher level of care.	{A 170}		

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{A 170}	Continued From page 32 Findings Included: A review of an itemized breakdown of social security funds owed to Resident #8 or the government agency, conducted on , revealed that the facility owed social security funds in the amount of $6642. This included $738 each month from . . . . . through . . . . . There was no evidence provided of any monies sent . . . to the government agency or to Resident #8. A record review of the resident record for Resident #8, conducted on . . . . . , revealed that Resident #8 was discharged from the facility on . . . . . Resident #8's contract dated noted a rate of $794.00 per month to be paid to the facility. Resident #8's record noted a social security income in the amount of $794.00 and not $738 per month. The amount $794 per month for nine months equaled an amount owed of $7546 and not $6642. Resident #8's contract noted that refunds would be provided 45 days following the final date of termination of residency. There was no evidence in Resident #8 that the resident received any refund. On , an attempt was made to review social security funds received by the facility for Resident #8 between through . . . . . The documents were not provided to review. On , an attempt to review social security funds that were sent . . . to the government agency for Resident #8 between through . . . . . The documents were not provided to review.	{A 170}		

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{A 170}	Continued From page 33 On , an attempt was made to review payments made to the receiving facility for Resident #8 from through . The documents were not provided to review. During an interview with the Administrator, conducted on at 09:50am, the Administrator stated that the government agency set up a payment plan to repay the social security funds received by the facility for Resident #8. The Administrator was unable to provide evidence that the government agency set up a payment plan. Class III	{A 170}		
{CZ814}	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the , , are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse	{CZ814}		

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{CZ814}	Continued From page 34	{CZ814}		

before referring an employee or potential employee for electronic , submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number.

This Statute or Rule is not met as evidenced by:
Based on record review and interview, the facility failed to maintain the employment status of employees within the facility's background screening clearinghouse employee roster for two employees (Staff D and E) of six sampled employees.

Findings Included:

A review of the facility's background screening clearinghouse employee roster, conducted on , revealed that Staff D and E were not listed as current employees of the facility.

A review of Staff D and E's employee records, conducted on , revealed that there were no dates of hire in Staff D and E's employee records.

A review of the complaint investigation, conducted on , revealed that Staff D was working at the facility before .

During an interview with the Administrator, conducted on at 12:19pm, the Administrator did not provide Staff E's date of hire and stated that Staff E was hired last week.

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{CZ814}	Continued From page 35 During an interview with the Fiscal Agent, conducted on [redacted] at 03:00pm, the Fiscal Agent stated that he had not added Staff D or E to the facility's background screening employee roster. Unclassified	{CZ814}		
{CZ815}	408.809(1)( ); 435.02(2); 435.06 FS Background Screening; Prohibited Offenses 408.809 Background screening; prohibited offenses.- (1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are considered employees for the purposes of conducting screening under chapter 435: (a) The licensee, if an individual. (b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider. (c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider. (d) Any person who is a controlling interest. (e) Any person, as required by authorizing statutes, seeking employment with a licensee or provider who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, [redacted] with a licensee or provider whose responsibilities require him or her to provide personal care or personal services directly to clients, or [redacted] with a licensee or provider to work 20 hours a week or more who	{CZ815}		

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{CZ815}	Continued From page 36	{CZ815}		

will have access to client funds, personal property, or living areas. Evidence of contractor screening may be retained by the contractor's employer or the licensee.

(3) All , , must be provided in electronic format. Screening results shall be reviewed by the agency with respect to the offenses specified in s. 435.04 and this section, and the qualifying or disqualifying status of the person named in the request shall be maintained in a database. The qualifying or disqualifying status of the person named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee's behalf.

(4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction:
(a) Any authorizing statutes, if the offense was a felony.
(b) This chapter, if the offense was a felony.
(c) Section 409.920, relating to Medicaid provider fraud.
(d) Section 409.9201, relating to Medicaid fraud.
(e) Section 741.28, relating to domestic violence.
(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.
(g) Section 784.03, relating to battery, if the victim is a adult as defined in s. 415.102 or a

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{CZ815}	Continued From page 37	{CZ815}		

patient or resident of a facility licensed under chapter 395, chapter 400, or chapter 429.
(h) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.
(i) Section 817.234, relating to false and fraudulent insurance claims.
(j) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.
(k) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.
(l) Section 817.505, relating to patient brokering.
(m) Section 817.568, relating to criminal use of personal identification information.
(n) Section 817.60, relating to obtaining a credit card through fraudulent means.
(o) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.
(p) Section 831.01, relating to forgery.
(q) Section 831.02, relating to uttering forged instruments.
(r) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.
(s) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.
(t) Section 831.30, relating to fraud in obtaining medicinal drugs.
(u) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony.
(v) Section 895.03, relating to racketeering and collection of unlawful debts.
(w) Section 896.101, relating to the Florida Money Laundering Act.
If, upon rescreening, a person who is currently

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{CZ815}	Continued From page 38 employed or . . . . . with a licensee and was screened and qualified under s. 435.04 has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency no later than 30 days after receipt of the rescreening results by the person. (5) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening. (6)(a) As provided in chapter 435, the agency may grant an exemption from disqualification to a person who is subject to this section and who: 1. Does not have an active professional license or certification from the Department of Health; or 2. Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification. (b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may grant an exemption from disqualification to a person who is subject to this section and who has	{CZ815}		

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{CZ815}	Continued From page 39 received a professional license or certification from the Department of Health or a regulatory board within that department and that person is providing a service within the scope of his or her licensed or certified practice. (7) The agency and the Department of Health may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, chapter 435, and authorizing statutes requiring background screening and to implement and adopt criteria relating to retaining . , pursuant to s. 943.05(2). (8) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this section, terminates the person against whom the report was issued, whether or not that person has filed for an exemption with the Department of Health or the agency. 435.06 Exclusion from employment.- (1) If an employer or agency has reasonable cause to believe that grounds exist for the denial or termination of employment of any employee as a result of background screening, it shall notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity. (2)(a) An employer may not hire, select, or otherwise allow an employee to have contact with any . . . . . person that would place the	{CZ815}		

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{CZ815}	Continued From page 40 employee in a role that requires background screening until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of employment. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select, or otherwise allow the employee to have contact with any [redacted] person that would place the employee in a role that requires background screening unless the employee is granted an exemption for the disqualification by the agency as provided under s. 435.07. (b) If an employer becomes aware that an employee has been [redacted] for a disqualifying offense, the employer must remove the employee from contact with any [redacted] person that places the employee in a role that requires background screening until the [redacted] is resolved in a way that the employer determines that the employee is still eligible for employment under this chapter. (c) The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of this chapter or place the employee in a position for which background screening is not required unless the employee is granted an exemption from disqualification pursuant to s. 435.07. (d) An employer may hire an employee to a position that requires background screening before the employee completes the screening process for training and orientation purposes. However, the employee may not have direct contact with [redacted] persons until the screening process is completed and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment.	{CZ815}		

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	AL11953318	A. BUILDING: _____ B. WING _____	R-C 03/29/2023

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{CZ815}	Continued From page 41 (3) Any employee who refuses to cooperate in such screening or refuses to timely submit the information necessary to complete the screening, including , if required, must be disqualified for employment in such position or, if employed, must be dismissed. (4) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages against, an employer that, upon notice of a conviction or for a disqualifying offense listed under this chapter, terminates the person against whom the report was issued or who was , regardless of whether or not that person has filed for an exemption pursuant to this chapter. 435.02 Definitions.-For the purposes of this chapter, the term: (2) "Employee" means any person required by law to be screened pursuant to this chapter, including, but not limited to, persons who are contractors, licensees, or volunteers. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that employees had an eligible level 2 background screening prior to working with residents for one of six employees (Staff E). Furthermore, the facility failed to obtain an eligible level 2 background screening every five years for two employees (Staff A and B) of six sampled employees. Findings Included: An employee record review for Staff A, conducted on , revealed that Staff A had a level 2 background screening eligibility dated which was greater than five years. Staff A was hired on .	{CZ815}		

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{CZ815}	Continued From page 42 An employee record review for Staff B, conducted on . . . . . , revealed that Staff B had a level 2 background screening eligibility dated which was greater than five years. Staff B was hired on . An employee record review for Staff E, conducted on . . . . . , revealed that Staff E's employee records did not contain evidence of an eligible level-2 background screening or her date of hire. During an interview with the Administrator, conducted on at 12:19pm, the Administrator agreed that Staff E's employee records did not contain evidence of an eligible level 2 background screening. The Administrator did not provide Staff E's date of hire and stated that Staff E was hired last week. The Administrator was unable to provide evidence of eligible level 2 background screenings for Staff A and B. Unclassified	{CZ815}		
{CZ816}	408.809(2) 435.05(2) 59A-35.090(2d-3b) Background Screening-Compliance Attestation 408.809 Background screening; prohibited offenses.- (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law	{CZ816}		

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{CZ816}	Continued From page 43 Enforcement to forward the person's [illegible] to the Federal Bureau of Investigation for a national criminal history record check unless the person's [illegible] are enrolled in the Federal Bureau of Investigation's national retained print [illegible] notification program. If the [illegible] of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit [illegible] electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the [illegible] to the Federal Bureau of Investigation for a national criminal history record check. The [illegible] shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print [illegible] notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person [illegible]. The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that: (a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section; (b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and	{CZ816}		

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{CZ816}	Continued From page 44 (c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency. 435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers: (2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if for any of the disqualifying offenses while employed by the employer. 59A-35.090 Background Screening. (2) Processing Screening Requests, Required Documents and Fees. (d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, , herein incorporated by reference, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-09106, and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Regulations_Forms.shtml. This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if for any disqualifying offense. (e) An administrator or chief financial officer must be screened and qualified prior to , , to the position.	{CZ816}		

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{CZ816}	Continued From page 45 (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the report and court disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to Section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with Section 435.06(3), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain a signed attestation of compliance with background screening requirements for two employees (Staff D and E) of six sampled employees. Findings Included: A review of Staff D and E's employee records, conducted on . . . . . , revealed that Staff D and E's employee records did not contain a signed attestation of compliance with background screening requirements. Staff D and E's employee records did not contain their dates of hire. During an interview with the Administrator,	{CZ816}		

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{CZ816}	Continued From page 46 conducted on . . . . . at 12:19pm, the Administrator agreed that Staff D and E's employee records did not contain a signed attestation of compliance with background screening requirements. The Administrator did not provide Staff D and E's dates of hire but stated that Staff E was hired last week. Unclassified	{CZ816}		
{A 000}	Initial Comments A revisit to complaint investigation (complaint numbers: 2023001036 and 2023002825) was conducted at Jeanette Boston ALF on . . . . . Deficiencies were identified at the time of survey.	{A 000}		
{A 008} SS=D	429.26( ) FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner's direct observation of the	{A 008}		

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{A 008}	Continued From page 47	{A 008}		

patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form, reflecting the resident's condition on the date the examination is performed, becomes a permanent part of the facility's record of the resident and must be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6.

(6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or , , nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must

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{A 008}	Continued From page 48 be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of , , require such assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a -to- medical examination completed by a health care practitioner as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 days before or within 30 days after the individual's admission to a facility pursuant to Section 429.26(5), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations, 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living,	{A 008}		

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{A 008}	Continued From page 49 3. Any nursing or [illegible] services required by the individual, 4. Any special diet required by the individual, 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication, 6. Whether the individual has signs or symptoms of [illegible] or any other communicable [illegible], which are likely to be transmitted to other residents or staff, 7. A statement on the day of the examination that, in the opinion of the examining health care practitioner, the individual's needs can be met in an assisted living facility; and, 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care practitioner. (b) When a health care practitioner conducts a medical examination, the examination must be recorded on the practitioner's form or on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, [illegible], which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-13531. Faxed or electronic copies of the completed form are acceptable. If AHCA Form 1823 is used, the form must be completed as instructed. 1. If the health care practitioner's form does not include all the examination items on AHCA Form 1823 or if AHCA Form 1823 is not completed fully, then the omitted items may be obtained by the administrator or designee either orally or in writing from the health care practitioner. The missing or omitted information must be obtained and documented in the resident's record within 30 days after the resident's admission to the facility.	{A 008}		

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{A 008}	Continued From page 50 2. Omitted or missing information received orally must include the name of the health care practitioner, the name and signature of the administrator or designee recording the information, and the date the information was provided. (c) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (d) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.26, F.S. and this rule. (e) Any orders issued by the health care practitioner conducting the medical examination for medications, nursing services, treatments, , , or therapeutic diets, may be attached to the health assessment. A health care practitioner may attach a DH Form 1896, Florida Form, for residents who do not wish to be administered in the case of or (f) A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be	{A 008}		

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{A 008}	Continued From page 51 conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain a health assessment form that was complete and accurate for one Resident (#5) of one sampled resident. Findings Included: A record review for Resident #5, conducted on , revealed that Resident #5 was admitted to the facility on under the facility's former ownership and transferred to this facility when it opened on . Resident #5's health assessment form dated did not include an elopement risk assessment. The health assessment form noted that Resident #5 required medication administration and required total care for bathing and . During an interview with the Administrator, conducted on at 11:21am, the Administrator agreed that Resident #5's health assessment form did not include an elopement risk assessment. The Administrator agreed that the facility did not employ a licensed nurse to administer medications. Administrator agreed that the facility did not obtain an updated health assessment form for Resident #5. Class III	{A 008}		
{A 025} SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26	{A 025}		

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{A 025}	Continued From page 52 (7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider	{A 025}		

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{A 025}	Continued From page 53 and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide appropriate care and services and supervision to meet the needs of one Resident (#3) that was known to be at risk for elopements and had reoccurring elopements. The lack of supervision and oversight placed Resident #3 at risk for harm or injury in the event of future elopements. Furthermore, the facility failed to maintain resident records with documentation of elopement events for one Resident (#3) of one sampled resident that eloped twice from the facility. Findings Included: During a review of complaint investigation, conducted on , revealed that Resident #3 had eloped from the facility on and and the facility failed to provide care and services to meet the resident's elopement prevention need. During observations, conducted on at	{A 025}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEANETTE BOSTON ALF	6916 N. 30TH STREET TAMPA, FL 33610

(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 025}	Continued From page 54	{A 025}		

09:10am, Staff A was pulling into the driveway to report for her on coming work duties. Staff B had left her work duties at an undetermined time before Staff A arrived. There was no other staff present in the facility. Staff A left Resident #3 in the main building from 09:22am through 09:42am when the employee was in the activity building. There was no other staff present in the main building. Staff A stated that the Administrator and the Fiscal Agent only work in the facility when herself or Staff B were not feeling well. Staff A stated that she and Staff B work alone in the facility. Staff A stated that she relieved Staff B of her work duties and Staff B relieves her. Staff A stated that "it's just the two of us that work here". Staff A stated that Resident #3 did not have identification on her person. Staff A was unable to provide a photograph of Resident #3. At 12:37pm, the Administrator left the facitliy and had not returned by the end of survey at 03:45pm.

During an interview with Staff A, conducted on at 09:15am, Staff A stated that Staff B had worked the night shift. At 09:22am, Staff A stated that Staff B must have left to catch the bus.

During an interview with Resident #1, conducted on at 09:23am, Resident #1 stated that Staff B just left.

During an interview with Resident #4, conducted on at 09:23am, Resident #4 stated that she did not know what time Staff B left but that it wasn't too long ago.

During an interview with Resident #6, conducted on at 09:24am, Resident #6 stated that Staff B had just left but did not know what

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{A 025}	Continued From page 55 time. A record review for Resident #3, conducted on , revealed that Resident #3's health assessment form dated noted that the resident had a diagnosis of Major and was an elopement risk. Resident #3 required supervision with and assistance with bathing, grooming, toileting, and self-administration of medications. Resident #3 required daily observation for wellbeing, whereabouts, and reminders for important tasks. There was no documentation regarding an elopement that took place on or near . There was no evidence that Resident #3's primary care provider and responsible party were notified related to the resident's two elopements. There was no evidence that the facility provided additional care and services or interventions to prevent future elopements for Resident #3 when she was exit-seeking on or after the elopements on and . Resident #3 did not have the date that she was admitted to the facility in her record. A review of the admission and discharge log, conducted on , the admission and discharge log noted that Resident #3 was admitted on which was inconsistent to documentation regarding Resident #3 as early as . During an attempt to review the facility's elopement response drills, conducted on , there were no elopement response drills provided. During an attempt to review re-education provided to staff regarding elopements after	{A 025}		

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{A 025}	Continued From page 56 Resident #3 eloped from the facility on and , conducted on , there was no elopement re-education provided to staff. A review of the staffing schedule, conducted on Wednesday, , revealed that the facility failed to have a staff schedule that reflected its twenty-four-hour staffing pattern. The schedule listed employees' first and last initial but not their names. Staff G was listed as working on Sundays from 02:00pm to 10:00pm, Fridays from 08:00 to 06:00pm, and Sundays from 09:00 to 06:00pm. There was no employee found with the initials. Tuesdays noted that Staff B was to work from 10:00pm to Wednesdays at 09:00am. Wednesdays noted that Staff A was to be on duty from 08:00am to 06:00pm and the Administrator from 02:00pm to 10:00pm. During an attempted telephone interview with Staff B, conducted on at 01:56pm, there was no answer. During an interview with Staff A, conducted on at 02:15pm, Staff A stated that Resident #3 eloped from the facility a few times but did not remember the exact dates. Staff A stated that she had to call police on one occasion and Staff B had to call the police twice. Staff A stated that there may have been another time but did not remember when and stated that it should be in the daily shift log book. A review of the daily shift log for Resident #3, conducted on , revealed that from through that Resident #3 had a history of not taking commands, exit seeking, ready to fight, and runs out of the house. The daily shift log noted that Resident #3 eloped	{A 025}		

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{A 025}	Continued From page 57 from the facility on . . . . . On . . . . . , while Staff A was folding clothes in the med room, Resident #1 came to her for a , . pill "only to catch [Resident #3] open the door to go outside" and "the alarm need to be fixed" and "[Resident #3] is so fast it is impossible to see her every move". There was no documentation related to Resident #3's elopement on . On . . . . . , staff noted that the employees were doing their best to help Resident #3 the best way they could by the resident not going to the road. On at 05:00pm, Staff B noted that Resident #3 was not taking command as usual and walking backwards and keep jumping over something. During an interview with the Administrator, conducted on at 09:45am, the Administrator stated that the Fiscal Agent was away in another State. During a telephone interview with the Fiscal Agent, conducted on . . . . . from 03:00pm to 03:26pm, the Fiscal Agent stated that Staff B should not have left before Staff A arrived at the facility. The Fiscal Agent stated that the doors to the main building had alarms, but the alarms did not work because they needed new batteries. The Fiscal Agent stated that he had known the batteries needed to be replaced since . . . . . The Fiscal Agent stated that the facility had not added additional staff to the staffing schedule. The Fiscal Agent stated that he had been in another State for four days because of his job in the other State and would not be at the facility. The Fiscal Agent stated that there were no elopement drills conducted with staff. The Fiscal Agent stated that Resident #3 would be relocating to a secured facility at the end of .	{A 025}		

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{A 025}	Continued From page 58 Class II	{A 025}		
A 030 SS=D	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 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	A 030		

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A 030	Continued From page 59 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 telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.-	A 030		

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A 030	Continued From page 60 (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility.	A 030		

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A 030	Continued From page 61 (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 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	A 030		

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A 030	Continued From page 62 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 , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder	A 030		

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A 030	Continued From page 63 . . . . . Hotline operated by the Department of Children and Families, and , 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 . . . . . or . . . . . under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to issue a 45-day notice of termination of residency that included the reason for residency termination, a statement that the resident may contact the State Long-Term Care Ombudsman Program for assistance in relocation, and the statewide toll-free telephone number for the program for one Resident (#3) of one sample resident. Findings Included: A record review for Resident #3, conducted on	A 030		

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A 030	Continued From page 64 . . . . . , revealed that Resident #3 was issued a 45-day notice of residency termination dated . . . . . signed by the Fiscal Agent. There was no indication that the 45-day notice was sent or given to Resident #3's responsible party. The discharge notice did not note the reason for residency termination, a statement that the resident may contact the State Long-Term Care Ombudsman Program for assistance in relocation, and the statewide toll-free telephone number for the program. During an interview with the Fiscal Agent, conducted on at 03:05pm, the Fiscal Agent agreed that the 45-day notice did not include the reason for termination, a statement that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation, or the statewide toll-free telephone number of the program. Class III	A 030		
{A 032} SS=G	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A	{A 032}		

Agency for Health Care Administration

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{A 032}	Continued From page 65 resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case	{A 032}		

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{A 032}	Continued From page 66 manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure proper elopement response standards were in place which placed one Resident (#3) of one sampled resident at risk for elopements. Furthermore, the facility failed to conduct elopement drills with all staff twice per year as required. The facility's noncompliance placed Resident #3 at risk of harm or injury related to reoccurring elopements. Findings Included: During observations, conducted on . . . . . at 09:10am, Staff A just drove up in the driveway of the facility for on coming shift duties. Staff B had left at an undetermined time prior to Staff A's arrival. There were no other staff present in the facility. The facility was not a locked and secured facility. Staff A left Resident #3 alone in the main building of the facility from 09:25am through 09:42am. There was one employee present and working with residents which included Resident #3. There was no additional staff present that provided 1:1 care and services for Resident #3. During an interview with Staff A, conducted on . . . . . at 09:22am, Staff A stated that Staff B must have left to catch the bus. Staff A stated that Resident #3 did not have identification on her person. Staff A was unable to provide a recent	{A 032}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEANETTE BOSTON ALF	6916 N. 30TH STREET TAMPA, FL 33610

(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 032}	Continued From page 67 photograph of Resident #3. Staff A stated that Resident #3 eloped from the facility on three occasions. Staff A was not able to provide the exact dates of Resident #3's elopements. Staff A stated that she worked alone in the facility and Staff B relieves her from duty. Staff A stated that Staff B worked alone in the facility, and she relieves Staff B from her duties. During an attempt to review the facility's elopement response policy and procedures, conducted on , the elopement response policy and procedures was not provided. A record review for Resident #3, conducted on , revealed that according to Resident #3's health assessment dated the resident had a diagnosis of Major and was at risk for elopements. There was no photograph of Resident #3 in the resident's record. During an attempt to review the facility's elopement drills, conducted on , there was no evidence of elopement drills provided. During an attempt to review additional elopement training for staff since Resident #3's three elopements, conducted on , additional elopement training was not provided. During a telephone interview with the Fiscal Agent, conducted on at 03:15pm, the Fiscal Agent stated that no elopement drills were conducted. The Fiscal Agent was unable to provide evidence of additional elopement training since Resident #3's elopements. The Fiscal Agent stated that Resident #3 would be relocating at the end of the month.	{A 032}		

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
	AL11953318	A. BUILDING: _____ B. WING _____	R-C 03/29/2023

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{A 032}	Continued From page 68 Class II	{A 032}		