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
	AL11964585	A. BUILDING: _____ B. WING _____	R-C 04/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMELIA SPRINGS ASSISTED LIVING	1550 NECTARINE STREET FERNANDINA BEACH, FL 32034

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{A 000}	Initial Comments A revisit to the change of ownership survey was conducted at Amelia Springs Assisted Living Facility on 04/04/2023. The provider had deficiencies at the time of the visit.	{A 000}		
{A 052}	429.256(3-5); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an insulin syringe that is prefilled with the proper dosage by a pharmacist and an insulin pen that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's hand or placing the dosage in another container and helping the resident by lifting the container to his or her mouth. (d) Applying topical medications. (e) Returning the medication container to proper storage.	{A 052}		

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{A 052}	Continued From page 1 (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a nebulizer, including removing the cap of a nebulizer, opening the unit dose of nebulizer solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the nebulizer. (4) Assistance with self-administration of medication does not include: (a) Mixing, compounding, converting, or calculating medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a cavity of the body. (d) Administration of parenteral preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with rectal, urethral, or vaginal preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.	{A 052}		

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{A 052}	Continued From page 2 (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be 18 years of age or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to	{A 052}		

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{A 052}	Continued From page 3 enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's infection control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, staff interview, and facility record review, the facility failed to ensure the unlicensed medication technicians did not administer medication to two of four sampled residents (Resident #3 and Resident #4). The findings include:	{A 052}		

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{A 052}	Continued From page 4 During the medication pass on 04/04/2023 at 11:25 am with Resident #3, Employee B, medication technician, stated she has been passing medications for 15 years. Employee B crushed Resident #3's oral medication and added it to applesauce. She used a plastic spoon and a medication cup to mix it up. She attempted to have Resident #3 hold the handle of the spoon and then put the medication into her mouth. Resident #3 did not appear to comprehend what the medication technician was asking her to do. She made no attempt to take hold of the spoon handle. Employee B attempted to put the spoon handle into Resident #3's hand and then hold the resident's hand to provide hand over hand assistance in order to have the resident participate in the medication administration. Resident #3 was not able to hold the handle of the spoon. She was saying words that did not make sense and her eyes were closed. Employee B then took the spoon and spoon fed the medication to the resident. During the medication pass observation Employee B was asked if she had been trained in assistance with medication administration versus administration of medications. She stated "Oh yes, ma'am. I know the difference, but [Resident #3] is not able to assist and I'd rather she get the medication she needs than to not give it. I have no choice really but to administer the medication to her." During the medication pass on 04/04/2023 at 11:35 am, Employee B asked Resident #4 if he could pull his skin down under his eye so she could drop the medication into his eye. He pulled the eyelid down but did not hold the vial for the drop in his right eye. He did not hold the eyelid down for the left eye. Employee B dropped the	{A 052}		

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{A 052}	Continued From page 5 medication into his eyes. He did not attempt to assist with holding the vial or dropping the eyedrops into his eyes. Review of Employee B's personnel file revealed a training certificate for a 2-hour update for medication technician training course she received on 02/28/2023, but no nursing license. During an interview with the Administrator on 04/04/2023 at 4:00 PM she confirmed that Employee B was not a licensed nurse and could not administer medication to the residents. When informed of the medication pass observations, she stated that Employee B was administering medication. Review of the facility policy and procedures for assistance with self-administration of medications revealed: The designated staff member shall provide supervision of self-administered medications as follows. 5. Assist the resident in the self-administration process and the return of unused medications to the container. Medications may be administered only by persons licensed to do so by order of the healthcare provider. Photographic evidence obtained. Class III	{A 052}		
A 077	429.176 FS; 429.52(4-5),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days	A 077		

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A 077	Continued From page 6 that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least 21 years of age; 2. If employed on or after October 30, 1995, have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections	A 077		

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A 077	Continued From page 7 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to July 1, 1997, are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the death of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or	A 077		

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A 077	Continued From page 8 fewer beds and all within a 15 mile radius of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to April 20, 1998, are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not simultaneously serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, June 2016, which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility Administrator failed to perform necessary duties to ensure two of four sampled residents were appropriate for continued residency (Resident #3 and #4), and failed to ensure the provision of services to one of four sampled residents both before and after a fall with injury (Resident #4).	A 077		

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A 077	Continued From page 9 The findings include: Review of Employee B's personnel file revealed a training certificate for a 2-hour update for medication technician training course she received on 02/28/2023. During the medication pass on 04/04/2023 at 11:25 AM with Resident #3, Employee B, medication technician, stated she has been passing medications for 15 years. Employee B was observed administering medication to Resident #3 after the resident was unable to hold the spoon herself. Employee B stated that because Resident #3 is not able to assist with her medication administration, she didn't meet the criteria to stay in this type of facility. Review of the clinical record for Resident #3 revealed the Health Assessment Agency for Healthcare Administration (AHCA) form 1823 dated 04/12/2022 revealed the resident was assessed as requiring assistance with self-administration of medication. Photographic evidence obtained. During the medication pass on 04/04/2023 at 11:35 AM with Resident #4, Employee B was observed administering the medication when Resident #4 stopped participating in the process. Resident #4 was observed with a dressing to his left hand and an abrasion to his face. Deficient practice was identified in January 2022 for unlicenssed staff administering medications to Resident #4. Correspondance from the facility received by the Agency on 02/28/2023, authored by the Administrator, indicated the corrective	A 077		

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A 077	Continued From page 10 action was to re-educate the employee who was observed administering the medication. Photographic evidence obtained. Review of the clinical record for Resident #4 revealed the Health Assessment Agency for Healthcare Administration (AHCA) form 1823 dated 03/28/2022 revealed the resident was assessed as requiring assistance with self-administration of medication. He was assessed as being a fall risk, and was diagnosed with glaucoma, blindness, and Alzheimer's. He was assessed as requiring assistance (staff provide physical assistance with resident participation) with toileting, transferring, self-care, eating, dressing, bathing, and ambulation. Review of progress notes did not indicate clarification had been recieved on the discrepencies between his 1823 and his actual abilities. These notes indicated Resident #4 fell and was sent to the hospital on 03/31/2023. Photographic evidence obtained. During an interview with the Assistant Administrator on 04/04/2023 at 1:00 PM she stated that Employee C was the only staff member present in the MC unit when Resident #4 fell on 03/31/2023. She confirmed that there was only one staff member scheduled to be working in the MC unit at the time of the incident. She stated it happened right before 9:00 AM, before her arrival. They sent Resident #4 to the hospital. He was bleeding from his forehead, his left hand and his left thigh. She confirmed that she does not work directly with the residents during her entire shift. She helps the direct care staff, if needed, but she works in her office a large part of the day. Her office was not in the MC unit building. She confirmed there were 13 residents in the memory care unit and 13 residents in the	A 077		

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A 077	Continued From page 11 assisted living unit at the time of the incident. The census was 26 on the day of the survey. During an interview with the Administrator on 04/04/2023 at 4:00 PM she confirmed that Employee B was not licensed to administer medication to the residents. She confirmed that Resident #3 is a hospice recipient and #4 is legally blind and they both were assessed as requiring assistance with medication self-administration only but would need to reassess whether they met criteria for continued residency. She confirmed that Employee C left Resident #4 on the toilet and he was not being assisted/supervised. She explained she put a sign in his bathroom for staff to know not to leave him unattended. She then found the sign, still on the copier machine, which had not been posted as of the time of the interview, four days after the fall. She also acknowledged she failed to file an Adverse Incident Report with the Agency. Class III	A 077		
A 079	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 6-15 212 16-25 253 26-35 294 36-45 335 46-55 375	A 079		

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A 079	Continued From page 12 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 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 Cardiopulmonary Resuscitation (CPR) 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 CPR 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	A 079		

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A 079	Continued From page 13	A 079		

requirements for both First Aid and CPR.
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 21 years of age 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 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

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	AL11964585	A. BUILDING: _____ B. WING _____	R-C 04/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMELIA SPRINGS ASSISTED LIVING	1550 NECTARINE STREET FERNANDINA BEACH, FL 32034

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A 079	Continued From page 14 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 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.	A 079		

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A 079	Continued From page 15 (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, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, facility record review, and staff interview, the facility failed to ensure staffing was provided to meet resident care and safety needs. One of four sampled residents, Resident #4, experienced a fall when staff left him unsupervised. Two of four residents sampled required medication administration the facility was not staffed to provide. The distribution of staff posed a risk for all residents in the event of an unscheduled service need. The findings include: During an interview with Employee C on 04/04/2023 at 10:12 AM, she stated that she had been working at this facility for approximately one month. She stated that Resident #4 recently fell the morning of 03/31/2023. After she assisted him in the bathroom, she left the room to provide care to another resident down the hall. Resident # 4 got up off the toilet and fell into his shower. She stated, "He usually does not get up on his own." She confirmed she was not in the bathroom with him when he fell. She stated, "We were short staffed, and I was working in the Memory Care (MC) unit by myself when he fell." She stated that they are often short staffed and	A 079		

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A 079	Continued From page 16 she is by herself in the MC unit with 13 residents, and was overwhelmed taking care of thirteen residents by herself. During an observation on 04/04/2023 at 11:35 AM, Resident #4 was seen with a red abrasion on the right side of his forehead the size of a fifty cent piece, and a white bandage wrap on his left hand. He was seated in a chair in his room staring straight ahead. Review of the clinical record for Resident #4 revealed the Health Assessment Agency for Healthcare Administration (AHCA) form 1823 dated 03/28/2022. Diagnoses included blindness and Alzheimer's. The resident was assessed as requiring assistance with toileting, transferring, dressing, bathing, and ambulation. The assessment form explained assistance as staff providing physical assistance with the resident's particpation. This form also noted he was a fall risk. Photographic evidence obtained. During an interview with the Assistant Administrator on 04/04/2023 at 1:00 PM she stated that Employee C was the only staff member present in the MC unit when Resident #4 fell on 03/31/2023. She confirmed that there was only one staff member scheduled to be working in the MC unit at the time of the incident. She stated it happened right before 9:00 AM, before her arrival. They then sent Resident #4 to the hospital. He was bleeding from his forehead, his left hand and his left thigh. She confirmed that she does not work directly with the residents during her entire shift. She helps the direct care staff, if needed, but she works in her office a large part of the day. Her office was not in the MC unit building. She confirmed there were 13 residents in the memory care unit and 13	A 079		

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A 079	Continued From page 17 residents in the assisted living unit at the time of the incident. The census was 26 on the day of the survey. Review of the facility staff schedule for the week of 03/30/2023 through 04/05/2023 revealed three main shifts: 7am-3pm, 3pm-11pm, and 11pm-7am. Two management personnel were also scheduled, plus dietary staff. One to three staff members were scheduled per shift to work in direct care positions, spread between two buildings. This placed multiple shifts with just one caregiver in each of the two buildings. Photographic evidence obtained. Further review of the schedule did not contain the names of any licensed nurses to administer medications. On 04/04/2023 at 11:25 AM, Employee B, medication technician, was observed preparing medications for Resident #3. Employee B crushed the medication and added it to applesauce. She attempted to have Resident #3 hold the handle of the spoon and then put the medication into her mouth, but Employee B was unsuccessful. Employee B then took the spoon and spoon fed the medication to the resident. Employee B explained she knew the difference between assisting and administering medications, but Resident #3 was not able to assist. She said, "I have no choice really but to administer the medication to her." Review of Employee B's personnel file revealed a training certificate for a 2-hour update for medication technician training course (for unlicensed personnel) she received on 02/28/2023. During an interview with the Administrator on	A 079		

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A 079	Continued From page 18 04/04/2023 at 4:00 PM she confirmed that Employee B was not a licensed nurse and could not administer medication to the residents. The Administrator also confirmed that Employee C left Resident #4 on the toilet and he was not being assisted/supervised. She stated that every person who requires assistance with toileting should not be left unattended. She confirmed that Employee C was the only staff member working in the MC unit at the time of the incident. She stated that they had a call out that day. When shown the schedule for 03/31/2023, it conflicted with her statement, and she confirmed that no other staff member was actually scheduled to be working in the MC unit except Employee C. She stated that she is having trouble hiring enough staff. She confirmed that the MC unit should have at least two staff members at all times due to the needs of the residents in that unit. Class II	A 079		
A 165	429.23(1-4 & 6-10) 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	A 165		

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A 165	Continued From page 19 required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. Death; 2. Brain or spinal damage; 3. Permanent disfigurement; 4. Fracture or dislocation 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.	A 165		

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A 165	Continued From page 20 (6) Abuse, neglect, or exploitation must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (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 observation, staff interview, and record	A 165		

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A 165	Continued From page 21 review, the facility failed to provide a preliminary report to the Agency For Health Care Administration (AHCA) within 1 business day after an occurrence of an adverse incident involving Resident #4 (one of four sampled residents). The findings include: During the medication pass observation on 04/04/2023 at 11:35 AM with Resident #4, he was observed to have a red abrasion on the right side of his forehead the size of a fifty cent piece and a white bandage wrap on his left hand. He was seated in a chair in his room staring straight ahead. During an interview with Employee C on 04/04/2023 at 10:12 AM she stated that she had been working at this facility for approximately one month. She stated that Resident #4 fell and hit his head, his hand, and his leg. She had assisted him to the bathroom. After he was seated on the toilet, she left the room to provide care to another resident down the hall. Resident # 4 got up off the toilet and fell into his shower. She stated, "He usually does not get up on his own." She confirmed she was not in the bathroom with him when he fell. She stated, "We were short staffed and I was working in the memory care (MC) unit by myself when he fell." She stated that they are often short staffed and she is by herself in the MC unit with 13 residents. During an interview with the Assistant Administrator on 04/04/2023 at 1:00 PM she stated that Employee C was the only staff member present in the MC unit when Resident #4 fell on 03/31/2023.	A 165		

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A 165	Continued From page 22 Review of the clinical record for Resident #4 revealed the Health Assessment Agency for Healthcare Administration (AHCA) form 1823 dated 03/28/2022 revealed the resident was assessed as requiring staff's physical assistance with all activites of daily living. It was documented he was a fall risk and was diagnosed with Alzheimer's and blindness. Photographic evidence obtained. Review of the facility incident report dated 03/31/2023 at 8:56 AM revealed Resident #4 had an unwitnessed fall. He was found on the floor by Employee C. The description of the incident read: Resident tried getting up from the bathroom toilet and fell. Incident occurred Friday, 3/31/2023. Appears to have fallen off toilet when trying to get up. Caused abrasion on right side of forehead and resident complained of left wrist pain. Transported to [local hospital] for evaluation and treatment. Outcome of examination no broken bones or significant injuries. Released back to facility at 4:44 PM. This section was signed by the Assistant Administrator. Outcome section read: Will remind resident often and post information staff to not leave resident unattended. Photographic evidence obtained. Review of the hospital discharge summary form dated 03/31/2023 revealed it read: Reason for visit: Fall. Diagnoses: Skin tear of left hand without complication, initial encounter; Abrasion; Head Injury. Imaging Tests: Computerized Tomography (CT) scan cervical spine without Intravenous (IV) contrast; CT head without IV contrast; X-ray left hand 3 or more views. Medications given: Diphtheria-Pertus (acell), tetanus (Boost RIX). Photographic evidence obtained.	A 165		

Agency for Health Care Administration

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A 165	Continued From page 23 During an interview on 04/04/2023 4:00 PM with the Administrator she confirmed that Employee C left Resident #4 on the toilet and he was not being assisted/supervised. She confirmed that Employee C was the only staff member working in the MC unit at the time of the incident. She confirmed that she had not filed an immediate one-day preliminary report with AHCA for the incident. Class III	A 165		