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
	AL11966599	A. BUILDING: _____ B. WING _____	03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HAVEN ASSISTED LIVING FACILITY	1525 HAVEN DR OVIEDO, FL 32765

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A re-licensure survey and generator monitoring was conducted at Lutheran Haven Assisted Living on . The facility had deficiencies at the time of the visit.	A 000		
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	A 078		

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A 078	Continued From page 1 assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 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 personnel record reviews and interviews, the facility failed to ensure 1 of 5 sampled staff submitted a written statement from a health care provider documenting that the individual did not have any signs or symptoms of communicable within 30 days after beginning employment (administrator) and failed	A 078		

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A 078	Continued From page 2 to ensure 2 of 5 sampled staff's personnel record contained evidence of a negative (..) examination on an annual basis (administrator and director of nursing (DON). Findings: 1. A review of DON's personnel record revealed a hire date of . . . . . The record contained only an written statement from a health care provider documenting that the DON did not have any signs or symptoms of communicable . . . . . The record did not contain evidence of a negative examination annually thereafter. On at 5:05 pm, a request was made of both the administrator and the DON to provide the DON's negative exam. On at 5:25 pm, the DON said she did not have an annual negative . exam. On . . . . . at 5:25pm, the DON stated the Administrator does not have a communicable . . . . . statement or . since hire. On . . . . . at 5:35 pm, the DON returned then said she remembered she did not have a test because there was a shortage of testing materials. A request was made for her to provide documentation provided by the Florida Department of Health or a licensed health care provider certifying that there was a shortage of testing materials to exempt her from the requirement. On . . . . . at 6:09 pm, the DON returned then said she was unable to locate anything from the Department of Health.	A 078		

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A 078	Continued From page 3 On . . . . . at 6:30pm, the Administrator and DON confirmed the findings. Class III	A 078		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52 (1)(a) 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. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (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	A 081		

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A 081	Continued From page 4 inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (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	A 081		

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A 081	Continued From page 5 . . . . . control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , ... , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident . . . . . , neglect, and , . The facility must use its . . . . . prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, 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	A 081		

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A 081	Continued From page 6 regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interview, the facility failed to have documented evidence to indicate the facility's policies and procedures were used when 4 of 5 sampled staff received the required in-service training as described in 59A-36.011 ( ) F.A.C. (B, C, administrator & DON). Findings: A review of caregiver B's personnel record revealed a hire date of . A review of caregiver C's personnel record revealed a hire date of . A review of the administrator's personnel record revealed a hire date of . A review of the DON's personnel record revealed a hire date of . A review of the DON's certificates of training on	A 081		

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A 081	Continued From page 7 elopement response, emergency preparedness and evacuation training and recognizing and reporting . . . . . , neglect and . . , ... revealed the DON signed all of them as the trainer. On at 4:35 pm, when asked how she trained herself, the DON replied that all training, including those that required the use of the facility's policies and procedures, were taken online then she used the facility's certificates because the training title on the online ones were not correct. A review of caregiver's B's and C's and the administrator's training revealed the same training was also taken online. Class III	A 081		
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 personnel record reviews and interview, the facility failed to have documented evidence to	A 090		

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A 090	Continued From page 8 indicate 4 of 5 sampled staff received at least one hour of training in the facility's policy and procedures regarding . . . . . ( ) that included information in Rule 59A-36.009, F.A.C. within 30 days of employment (B, C, administrator & DON). Findings: A review of caregiver B's personnel record revealed a hire date of . . . . . . A review of caregiver C's personnel record revealed a hire date of . A review of the administrator's personnel record revealed a hire date of . . . . . . A review of DON's personnel record revealed a hire date of . A review of DON's certificate of training on policy and procedures revealed DON signed it as the trainer. On at 4:35 pm, when asked how she trained herself, the DON replied that all training, including those that required the use of the facility's policies and procedures, were taken online then she used the facility's certificates because the training title on the online ones were not correct. A review of caregiver's B's and C's and the administrator's training revealed the same training was also taken online. Class III	A 090		
A 093 SS=D	59A-36.012(2) FAC Food Service - Dietary Standards	A 093		

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A 093	Continued From page 9 (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No =Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_ Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on	A 093		

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A 093	Continued From page 10 the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2	A 093		

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A 093	Continued From page 11 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observations, facility's record reviews, and interviews, the facility failed to maintain 6 months of dated, signed menus by a licensed dietician and a 3-day supply of sufficient drinking water according to the resident census. Findings: Observations on at 12:55pm revealed the facility did not have a 3-day supply of sufficient drinking water according to the resident census of 41. 3-day supply x 41 residents are equivalent to 123 gallons. Review of the menus provided were not dated or signed by a licensed	A 093		

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A 093	Continued From page 12 dietician. On . . . . . at 12:57pm The District Manager stated, "we have collapsible containers, 12 boxes of 2.5 gallons which hold 240 gallons of water. So, whenever we need them, we just fill them up. No, we do not have any actual water, just containers." On at 12:59pm The Chef stated, "no we've never had actual water just the collapsible containers and these are the only menus that we have." The Chef stated we do not have six months of dated menus for 2023. We make the menus to send to the dietician for review, she approves and returns to us. We've sent her the menus for Summer 2024, but she has not returned yet. Review of the Facility's Emergency Plan revealed on page 87, Section II, C stated, Water - 1 . . . gallons per resident, per day. In addition, collapsible containers are available. Based on the Emergency Plan, the facility should have 184.5 gallons of water. On at 1:10pm The Director of Nursing stated after review of the plan on page 87, Section II, C, "yes, there should be 1 ½ gallons here." On at 1:12pm The Administrator stated the water is in the kitchen. Oh, they don't have any water. Let me go check with the Chef and District Manager. On . . . . . at 1:15pm The District Manager stated, "yes, the Administrator informed me that we should have water here in the facility along with the collapsible containers. I've ordered some	A 093		

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A 093	Continued From page 13 water to be delivered tomorrow." On ..... at 1:18pm The Administrator confirmed there is no water in any locations of the facility. I've told the District Manager to order, and I will provide a copy of the receipt. On at 1:33pm The Administrator provided a copy of the receipt which stated 25 cases containing 6 bottles totaling 150 gallons. The Administrator also provided a 2nd receipt and photocopy of 36 gallons purchased from the local store to meet the minimum requirements. Class III	A 093		
AE208 SS=D	59A-36.021(8) FAC 429.07(3)(b)3, FS ECC - Records 59A-36.021(8) RECORDS. (8) RECORDS. In addition to the records required in rule 59A-36.015, F.A.C., a facility providing extended congregate care services must maintain the following: (a) The service plans for each resident receiving extended congregate care services; (b) The nursing progress notes for each resident receiving nursing services from the facility's staff; (c) Nursing assessments; and, (d) The facility's extended congregate care policies and procedures. 429.07 (3)(b), FS 3. A facility that is licensed to provide extended congregate care services shall maintain a written progress report on each person who receives such nursing services from the facility's staff which describes the type, amount, duration, scope, and outcome of services that are	AE208		

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
	AL11966599	A. BUILDING: _____ B. WING _____	03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HAVEN ASSISTED LIVING FACILITY	1525 HAVEN DR OVIEDO, FL 32765

(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
AE208	Continued From page 14 rendered and the general status of the resident's health. A registered nurse, or appropriate designee, representing the agency shall visit the facility at least twice a year to monitor residents who are receiving extended congregate care services and to determine if the facility is in compliance with this part, part II of chapter 408, and relevant rules. One of the visits may be in conjunction with the regular survey. The monitoring visits may be provided through contractual arrangements with appropriate community agencies. A registered nurse shall serve as part of the team that inspects the facility. The agency may waive one of the required yearly monitoring visits for a facility that has: a. Held an extended congregate care license for at least 24 months; b. No class I or class II violations and no uncorrected class III violations; and c. No ombudsman council complaints that resulted in a citation for licensure. This Statute or Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure the nursing progress notes described the scope, amount, duration, and outcome of services that are rendered and the general status of the resident's health for 1 of 3 sampled residents who received an Extended Congregate Care (ECC) service for care (#7). Findings: A review of resident #7's record revealed a facility admission date of . The resident's medical history included Major ,	AE208		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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AE208	Continued From page 15 and On at 9:50 am, the DON identified resident #7 as receiving ECC for care on the resident's left lower . On at 10:13 am, the resident was seen sitting on her bed. A brown wrap was seen on her left lower . The resident said a nurse dressed the and she was not sure how often. On a health care provider ordered to the left lower daily x14 days. On a care provider documented the was a . On a health care provider ordered to cleanse the left lower with normal dry, apply Silver and cover with foam border daily and as needed. On a health care provider ordered 100 milligrams (mg) by twice daily x10 days for to the . On a health care provider ordered to wrap the left lower with cohesive bandage daily after change. On a health care provider changed the care to and foam daily. A review of the facility's ECC nursing progress notes, which began on , revealed the notes documented only to continue ECC service	AE208		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966599	A. BUILDING: _____ B. WING _____	03/05/2024

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AE208	Continued From page 16 for treatment to left lower . On ..... at 12:20 pm, the findings were discussed with the DON, who said the progress notes she provided were the only ones. In addition, the DON confirmed she conducted an assessment of the ..... at least monthly. However, her documentation did not describe her assessment of the ..... . On ..... at 12:40 pm, the DON returned then said she reviewed the documentation and could not provide anything else. Class III	AE208		