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
	AL11965505	A. BUILDING: _____ B. WING _____	11/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

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CZ841	408.823( ) FS In-person Visitation (1) This section applies to , 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 , , 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 control and education policies for visitors; screening, personal protective equipment, and other 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 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 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	CZ841		

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CZ841	Continued From page 1 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 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,	CZ841		

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CZ841	Continued From page 2 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 interview and record review, it was determined that the facility failed to meet the Florida State regulation requirements for Visitation policies and procedures that include in-person visitation guidelines. The findings include: During a relicensure survey on at approximately 10:30 AM, the Administrator was informed to provide a copy of the Visitation Policies and Procedures including in-person visitation guidelines for review. The Administrator was asked if the facility had a website listing the vistation policy. He stated "no". Therefore, the facility was unable to demonstrate that the facility established a policy that address the following required components. a) control education for visitors. b) screening. c) PPE. d) essential caregiver designation. e) visit length (essential caregivers must be allowed visitation at least two hours daily). f) consensual physical contact g) designation of a person responsible for ensuring staff adhere to the policies and procedures. h) visitation in end-of-life situations. i) visitation for a resident, client, or patient who was living with family before being admitted to the	CZ841		

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CZ841	Continued From page 3 provider's care and is struggling with the change in environment and lack of in-person family support. j) visitation in the event the resident, client, or patient is making one or more major medical decisions. k) visitation when a resident, client, or patient is experiencing emotional distress or grieving the loss of a friend or family member who recently . l) visitation when a resident, client, or patient needs cueing or encouragement to eat or drink which was previously provided by a family member or caregiver. m) visitation when a resident, client, or patient who used to talk and interact with others is seldom speaking. During an interview on at 1:30 PM the Administrator acknowledged that, the facility did not have the Visitation policies and procedures that include in-person visitation guidelines available at the time of the survey. No additional documentation was provided. Class	CZ841		
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: 1. A person with a break in service of more than 90 days from a position that requires screening	CZ814		

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CZ814	Continued From page 4 by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. 2. Effective , or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity. (c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse. 1. Before , initial status and any changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person ' s status has been made. 2. Effective , initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person ' s status has been made. (d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic submission to the Department of Law Enforcement. The registration must include the person ' s full first name, middle	CZ814		

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CZ814	Continued From page 5 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 observation, interview and record review, it was determined that the facility failed to register employees for the Background Screening with the Clearinghouse and maintained employment status for 2 out of 4 sampled staff (Staff C and D) The findings include: This surveyor entered the facility for the biannual survey on at approximately 10:00 AM during the survey, this surveyor observed the staffing schedule posted in the common area reflecting Staff C (Caregiver) with her name on it. 1) During an interview on at approximately 10:45 AM the Administrator was informed to provide the facility personal file for Staff C. Review of the personal file revealed no documentation for the Background Screening with the Clearinghouse in her file. The Administrator stated that at this time the facility only has one resident and therefore Staff C services are required as needed (On Call). He stated Staff C provides direct care to the residents during her shift. Review of the Background Screening Clearinghouse on revealed Staff C is not listed in the facility employee roster.	CZ814		

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CZ814	Continued From page 6 2) During an interview on at approximately 10:50 AM the Administrator was informed to provide the facility personal file for Staff D (Caregiver). The Administrator stated Staff D no longer work at the facility, he was asked to provide an end date for employment. He stated at this time he does not remember. Review of the Background Screening Clearinghouse on revealed Staff D with a hire date of and it does not reflect an end date of employment. During an interview on at approximately 1:30 PM the Administrator acknowledged the findings. No additional documentation was provided Unclassified	CZ814		
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 Enforcement to forward the person's , , to the Federal Bureau of Investigation for a national criminal history record check unless the person's , , are enrolled in the Federal	CZ816		

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CZ816	Continued From page 7 Bureau of Investigation's national retained print notification program. If the ␣, ␣ 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 ␣, ␣ electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the ␣, ␣ to the Federal Bureau of Investigation for a national criminal history record check. The ␣, ␣ shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print 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 ␣, ␣. 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 (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.	CZ816		

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CZ816	Continued From page 8 435.05 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. (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	CZ816		

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CZ816	Continued From page 9 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, it was determined the facility did not have complete Attestation of Compliance for 1 of out 4 sampled Staff (Staff B). The findings include: Review of personnel file conducted on for Staff B (Caregiver) with a hire date of . Staff B did not have a completed Attestation form in her employee file During an interview on at approximately 1:30 PM the administrator acknowledged the findings. No additional documentation was provided. Unclassified	CZ816		

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CZ830	Continued From page 10	CZ830		
CZ830	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers.	CZ830		

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CZ830	Continued From page 11 (3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider; 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes.	CZ830		

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CZ830	Continued From page 12 (4) . . . Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure its Comprehensive Emergency Management Plan (CEMP) was up-to-date and approved by the Local County Emergency Management Division. The findings include: Review of the facility CEMP's file provided on , revealed missing notification of the facility's current CEMP approval status. It could not be determined any prior CEMP approvals. A review of the Local County Emergency Management Division's database on documented CEMP status as Draft. Further review revealed no entries or information documenting that the facility had submitted the request for an approval of their CEMP. During an interview with the Administrator on at approximately 10:15 AM the Administrator was asked to confirm if the facility has a fixed or portable generator, and he stated due to a repossession of the fixed generator in early 2024 (unable to provide date of the repossession) he had to make some changes by replacing it with a portable generator instead. The Administrator was asked if he had reported the changes to the Local County Emergency Management Division and he stated no. He stated due to outstanding violations from the local	CZ830		

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CZ830	Continued From page 13 Fire Department was unable to move forward with CEMP submission until all violations are cleared. During an interview with the Administrator on at 1:30 PM the Administrator acknowledged the findings. No additional documentation was provided. Class III	CZ830		

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A 081	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 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		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	11/09/2024

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A 081	Continued From page 1 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. (b) Staff who provide direct care to residents	A 081		

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A 081	Continued From page 2 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. 2. All facility staff shall demonstrate an	A 081		

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A 081	Continued From page 3 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, it was determined the facility failed to provide documented Elopement Drills conducted twice a year, the facility failed to ensure complete Preservice Orientation (Staff In-Service Training) the facility failed to ensure staff had complete training in Nutritional and Safe Food Handling for 2 of out 4 sampled staff (Staff A and B) The findings include: 1)During review of the personnel file on for Staff B (Caregiver) with a hire date of revealed no documentation for Elopement drills for the year 2023. Further review of the file revealed no documentation of the Preservice Orientation and 1-hour training in Nutritional and Safe Food Handling in her file. During an interview with the Administrator on at approximately 10:15 AM he was informed to provide documentation for Elopement drills for the year 2023 and documentation of the Preservice Orientation for Staff B. The Administrator was asked if, Staff B prepares and serves food to the residents during her shift (breakfast and Dinner) and he stated yes. During an interview with the Administrator on at approximately 10:45 AM he stated	A 081		

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A 081	Continued From page 4 he prepares and serves food to residents when Staff B is not available. 2) During review of the personnel file on for Staff A (Administrator) with a hire date of revealed no documentation for 1-hour training in Nutritional and Safe Food Handling in his file. During an interview on at approximately 1:30 PM the Administrator stated he did not have documents readily available for review at the time of survey. He acknowledged the findings. No additional documentation was provided. Class	A 081		
A 084	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label;	A 084		

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A 084	Continued From page 5 providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, , dosage forms, and , , , and dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such	A 084		

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A 084	Continued From page 6 reactions; h. Assist residents with syringes that are prefilled with the proper dosage by a pharmacist and , that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection; i. Assist with ; j. Use a to perform testing; k. Assist residents with and continuous positive airway pressure (CPAP) devices, excluding the titration of the levels; l. Apply and remove stockings and hosiery; m. Placement and removal of bags, excluding the removal of the or manipulation of the site; and, n. Measurement of , , rate, temperature, and , rate. (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in	A 084		

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A 084	Continued From page 7 sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that staff who provide assistance with self-administration of medications had completed 2-hour continuing education training for assistance with self-administer medications for 2 out of 4 sampled staff (Staff A, and B) The findings include: During an interview with Staff A (Administrator) on at approximately 10:45 AM he stated he covers the weekend shift as live-in (24 hours) and he confirmed that he assists with self-administration of medications. The Administrator stated Staff B (Caregiver) assist with self-administration of medications Monday through Friday (Day Shift). During a record review of Staff A on 11/09/2024 with a hire date of , it was revealed that Staff A had no documentation of the required 2-hour annual training assisting with	A 084		

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A 084	Continued From page 8 self-administration of medications for the years 2023 and 2024. The last training documented in his file is dated . Further review revealed the initial 6-hour training was not in the personnel file at the time of the survey. During a record review of Staff B on 11/09/2024 with a hire date of , it was revealed that Staff B had no documentation of the required 2-hour annual training assisting with self-administration of medications for the year 2024. The last training documented in her file is dated . Further review revealed the initial 6-hour training was not in her personnel file at the time of the survey. During an interview on at 1:30 PM the Administrator acknowledged the findings. He was given an opportunity to provide documentation to support the missing training. No additional documentation was provided. Class III	A 084		
A 085	59A-36.011(7) FAC Training - Nutrition & Food Service (7) NUTRITION AND FOOD SERVICE. The administrator or person designated by the administrator as responsible for the facility's food service and the day-to-day supervision of food service staff must obtain, annually, a minimum of 2 hours continuing education in topics pertinent to nutrition and food service in an assisted living facility. This requirement does not apply to administrators and designees who are exempt from training requirements under paragraph 59A-36.012(1)(b). A certified food manager, licensed dietician, registered dietary technician or	A 085		

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A 085	Continued From page 9 health department sanitarian is qualified to train assisted living facility staff in nutrition and food service. This Statute or Rule is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure the Administrator, or designated person responsible for the facility's Food Service had completed annual continuing education for 1 out of 4 sample staff (Staff A) The findings include: During an interview with the Administrator on at approximately 10:45 AM, he stated he is the facility's Food Service designee. The Administrator was informed to provide documentation for the Food Service continuing education. Review of the facility's personnel record on for Staff A (Administrator) with a hire date of revealed last documented continuing education for Nutrition and Food Service was dated . During an interview on at 1:30 PM the Administrator stated, he does not have documentation to support updated annual training of continuing education for Food Service. Class III	A 085		
A 093	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living	A 093		

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A 093	Continued From page 10 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 the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks,	A 093		

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A 093	Continued From page 11 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 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,	A 093		

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A 093	Continued From page 12 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 observation, interview and record review, it was determined that the facility failed to ensure the annual Food Menu was up to date. The Facility failed to ensure that a 3-day emergency food supply of non-perishable food was not expired at the time of the survey. The findings include: During a facility tour on between 10:00 AM and 2:00 PM, this surveyor observed an expired food menu posted on the refrigerator. The menu posted showed an effective date of and an expiration date . Further observation revealed that the 3-day emergency food supply (located in the common	A 093		

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A 093	Continued From page 13 area - hallway/storage room) had multiple expired non-perishable food items. It was noted a majority of the food had an expiration date of 2022 or 2023. At this time, the Administrator was interviewed regarding the expired food, in which he acknowledged the expiration dates. During an interview on at approximately 10:45 AM the Administrator was requested to provide the facility's current annual Food Menu. The Administrator was unable to provide a current menu for review. The only menu available was the expired menu posted on the refrigerator. During an interview on at 1:30 PM, the Administrator acknowledged the findings. Class III	A 093		
A 120	429.17(3) .275(1); 59A-36.013(1) FAC Fiscal - Financial Stability 429.17 (3) In addition to the requirements of part II of chapter 408, each facility must report to the agency any adverse court action concerning the facility's financial viability, within 7 days after its occurrence. The agency shall have access to books, records, and any other financial documents maintained by the facility to the extent necessary to determine the facility's financial stability. 429.275 (1) The administrator or owner of a facility shall maintain accurate business records that identify, summarize, and classify funds received and expenses disbursed and shall use written	A 120		

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A 120	Continued From page 14 accounting procedures and a recognized accounting system. 59A-36.013 Fiscal Standards. (1) FINANCIAL STABILITY. The facility must be administered on a sound financial basis in order to ensure adequate resources to meet resident needs pursuant to the requirements of chapter 408, part II, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. This Statute or Rule is not met as evidenced by: Based on interviews, observation and record review, it was determined that the facility failed to ensure it was operating on a sound financial basis and maintaining financial stability. It was determined that the facility failed to have sufficient financial resources available to maintain the monthly payments for the facility generator and to make needed repairs. The findings include: During an interview with the Administrator on at approximately 10:00 AM, he stated the generator was repossessed. This surveyor requested to see where the designated area for the generator was located. At this time, the Administrator provided the exact location for observations. An observation revealed the generator was located on the patio of the house, as confirmed by the Administrator. The area was noted to be without the fixed generator, it had been removed. During an interview with the Administrator on at approximately 10:30 AM. He stated the generator was repossessed in early 2024 and he does not remember the exact date of the repossession. The Administrator was asked to	A 120		

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	AL11965505	A. BUILDING: _____ B. WING _____	11/09/2024

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A 120	Continued From page 15 provide an explanation as to why the generator was repossessed. The Administrator stated there are two financial components that resulted in the generator repossession. He stated the following: A) $30,000 amount for the Generator Unit, with monthly payments of $500 for 18 months to the local generator supplier/company to be paid by the facility. B) An initial $5,000 down payment that was borrowed from a financial institution (Bank/third party) for the purchase of the generator. The Administrator stated that having to pay for the generator (supplier) monthly, third party financial institution (Bank) and the local city fire department for unresolve inspections had put him on financial strain, therefore not able to make those monthly payments as scheduled on his contract. During confidential interviews on and with the local fire department and generator supplier it was determined that the facility has past invoices and unresolved violations that yield to monetary resolution, as a result of the uncorrected violations. It was also confirmed as of the date of the survey that the violations have not been corrected by the facility. During record review on of the facility's annual Fire Inspection dated revealed the following violations: 1) Hallandale Beach - Construction or work without a permit. Possible unpermitted construction or alteration. Inspector Notes: Generator removal without permit. It was advised the generator company removed the generator due to non-payment: Violation found , Will be rechecked on or after , Violation not repaired.	A 120		

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A 120	Continued From page 16 2)Fire alarm system is required to have annual inspection: Violation found , Will be rechecked on or after , Violation not repaired. 3)Fire alarm system is in need of repair: Violation found , Will be rechecked on or after , Violation not repaired 4) Inspector Notes: Diaper not functioning properly: Violation found , Will be rechecked on or after , Violation not repaired. 5) Fire sprinkler system is required to have annual inspection: Violation found , Will be rechecked on or after , Violation not repaired. 6) Replace damaged, painted or corroded sprinkler heads: Violation found , Will be rechecked on or after , Violation not repaired. 7) Emergency power supply required: Violation found , Will be rechecked on or after , Violation not repaired. 8) Fire extinguishers need service or replacement: Violation found , Will be rechecked on or after , Violation not repaired. 9) truss sign required: Violation found , Will be rechecked on or after , Violation not repaired During a record review on of the facility's generator supplier notice revealed the following:	A 120		

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A 120	Continued From page 17 A) Invoice dated from the generator supplier with Bill To and Service To the facility's Administrator name and facility address. Total amount of $22, 267.31 / Paid $0.00 / Balance of $22,267.31 Past due. B) Letter (undated) from the generator supplier addressed to the Administrator (facility address) documented supplier had made several attempts to collect on past due amount of $22,267.31 and it was very important to get in touch with the supplier regarding balance or supplier will be forced to take further action. The undated letter was signed by the supplier's bookkeeper. C) An agreement letter dated , signed and dated by both parties (Administrator and generator supplier). The agreement letter documented the following. Balance due of $12,767.31 The following is a payment plan for the above balance due on your generator project. You agree to pay [Generator Company] the amount of $1500 per month until paid in full on the 18th of every month. During a further confidential interview, it was revealed the generator was installed in , the total cost of the generator and installation was $26,187.43. The facility made a down payment of $5237.40 plus an additional third-party financing payment of $9500 in 2022 (at the time of initial down payment). The facility stopped making payments in 2022 (last payment). The facility upon agreement in , with the generator company agreed to make monthly payments of $1500(for 18 months) to ensure final payment of the outstanding balance of $12,767.31 and to bring the account current due to delinquent status. The facility made a total of 3	A 120		

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A 120	Continued From page 18 monthly payments (total of $4500) per the agreement, no further payments received. The final balance due before repossession was $8267.31. The generator was repossessed in . During an interview on at approximately 1:30 PM, the Administrator acknowledged he had financial hardship resulting in a repossession of the facility generator follow by unresolve violations from the local city department. Class II	A 120		
A 152	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes,	A 152		

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A 152	Continued From page 19 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that existing structural systems and appurtenances are maintained in good working order. The facility failed to provide a safe living environment for all residents that reside at the facility. The findings include: During a review of the facility's record revealed that the annual Fire Inspection dated . Further review of the inspection report revealed prompt action required by the facility for the following 18 violations as follows: 1) Emergency preparedness plan required: Violation found , Will be rechecked on or after , Violation not repaired. 2) Emergency preparedness drills need to be documented: Violation found , Will be rechecked on or after , Violation not	A 152		

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A 152	Continued From page 20 repaired. 3) Fire alarm system is required to have annual inspection: Violation found , Will be rechecked on or after , Violation not repaired. 4) Provide copy of annual fire alarm system inspection report: Violation found , Will be rechecked on or after , Violation not repaired. 5) Fire alarm inspection tag must be properly posted: Violation found , Will be rechecked on or after , Violation not repaired. 6) Fire alarm system is in need of repair: Violation found , Will be rechecked on or after , Violation not repaired. 7) Inspector Notes: Diaper not functioning properly: Violation found , Will be rechecked on or after , Violation not repaired. 8) Fire sprinkler system is required to have annual inspection: Violation found , Will be rechecked on or after , Violation not repaired. 9) Annual inspection tag must be posted: Violation found , Will be rechecked on or after , Violation not repaired. 10) Provide annual inspection report: Violation found , Will be rechecked on or after , Violation not repaired. 11) Replace damaged, painted or corroded	A 152		

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A 152	Continued From page 21 sprinkler heads: Violation found , Will be rechecked on or after , Violation not repaired. 12) Emergency power supply required: Violation found , Will be rechecked on or after , Violation not repaired. 13) Fire extinguishers need service or replacement: Violation found , Will be rechecked on or after , Violation not repaired. 14) Building address must be visible: Violation found , Will be rechecked on or after , Violation not repaired. 15) Update keys in Knox box: Violation found , Will be rechecked on or after , Violation not repaired. 16) Label keys in Knox box: Violation found , Will be rechecked on or after , Violation not repaired. 17) truss sign required: Violation found , Will be rechecked on or after , Violation not repaired. 18) Hallandale Beach - Construction or work without permit. Possible unpermitted construction or alteration. Inspector Notes: Generator removal without permit. Was advised the generator company removed the generator due to non payment: Violation found , Will be rechecked on or after , Violation not repaired. During an interview on at approximately 11:00 AM, the Administrator was given an opportunity to provide documentation	A 152		

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A 152	Continued From page 22 indicating the aforementioned violations had been corrected. The Administrator stated he has financial hardship at this time and all violations mentioned above are still pending. He was also unable to provide a date in the near future in which these items would be corrected. Class III	A 152		
A 162	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a	A 162		

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A 162	Continued From page 23 therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A ⌄ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their ⌄ recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that ⌄ not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an ⌄ recipient, a copy of	A 162		

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A 162	Continued From page 24 the Department of Children and Families form Alternate Care Certification for , , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for	A 162		

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A 162	Continued From page 25 facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided 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 observation, record review and interview it was determined, the facility failed to maintain resident records on premises that include a copy of Health Assessment (AHCA Form1823), residents orders for medication, ⌄ record, copy of the resident contract, nursing services or other services to be provided, supervised or implemented by the facility that require a health care provider's order for 1 out of 1 sampled resident (Resident#1). The findings include: During a tour on between 10:00 AM and 2:00 PM this surveyor observed Resident #1 in his room. During an interview on at approximately 10:00 AM, Resident #1 stated, he is and depends on staff to assist with his daily personal care. During record review of Resident#1's file revealed an AHCA Form1823 documenting another facility's name. Further review of the chart revealed no documentation of Resident #1's orders for medication, ⌄ record, copy of the resident contract, nursing services or other services provided, supervised or implemented by the facility at the time of survey. During an interview on at approximately 10:45 AM the Administrator was informed to provide copies of the above-mentioned documents. During an interview on at 1:30 PM the Administrator acknowledged the missing	A 162		

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A 162	Continued From page 26 documents in Resident #1's chart. No additional documentation was provided during the survey. Class III	A 162		
A 200	59A-36.025 FAC Emergency Environmental Control 59A-36.025 Emergency Environmental Control for Assisted Living Facilities. (1) DETAILED EMERGENCY ENVIRONMENTAL CONTROL PLAN. Each assisted living facility shall prepare a detailed plan ("plan") to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency environmental control in the event of the loss of primary electrical power in that assisted living facility which includes the following information: (a) The acquisition of a sufficient alternate power source such as a generator(s), maintained at the assisted living facility, to ensure that current licensees of assisted living facilities will be equipped to ensure air temperatures will be maintained at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. 1. The required temperature must be maintained in an area or areas, determined by the assisted living facility, of sufficient size to maintain residents safely at all times and that is appropriate for resident care needs and life safety requirements. For planning purposes, no less than twenty (20) net square per resident must be provided. The assisted living facility may use eighty percent (80%) of its licensed bed capacity as the number of residents to be used in the to determine the required square footage. This may include areas that are less than the entire assisted living facility if the	A 200		

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A 200	Continued From page 27 assisted living facility's comprehensive emergency management plan includes allowing a resident to congregate when he or she desires in portions of the building where temperatures will be maintained and includes procedures for monitoring residents for signs of heat related injury as required by this rule. This rule does not prohibit a facility from acting as a receiving provider for evacuees when the conditions stated in Section 408.821, F.S. and subsection 59A-36.019(5), F.A.C., are met. The plan shall include information regarding the area(s) within the assisted living facility where the required temperature will be maintained. 2. The alternate power source and fuel supply shall be located in an area(s) in accordance with local zoning and the Florida Building Code. 3. Each assisted living facility is unique in size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and staffing characteristics. Accordingly, this rule does not limit the types of systems or equipment that may be used to achieve temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. The plan shall include information regarding the systems and equipment that will be used by the assisted living facility and the fuel required to operate the systems and equipment. a. An assisted living facility in an evacuation zone pursuant to Chapter 252, F, S. must maintain an alternative power source and fuel as required by this subsection at all times when the assisted living facility is occupied but is permitted to utilize a mobile generator(s) to enable portability if evacuation is necessary. b. Assisted living facilities located on a single	A 200		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 200	Continued From page 28 campus with other facilities under common ownership, may share fuel, alternative power resources, and resident space available on the campus if such resources are sufficient to support the requirements of each facility's residents, as specified in this rule. Details regarding how resources will be shared and any necessary movement of residents must be clearly described in the emergency power plan. c. A multistory facility, whose comprehensive emergency management plan is to move residents to a higher floor during a flood or surge event, must place its alternative power source and all necessary additional equipment so it can safely operate in a location protected from flooding or storm surge damage. (b) The acquisition of sufficient fuel, and safe maintenance of that fuel at the facility, to ensure that in the event of the loss of primary electrical power there is sufficient fuel available for the alternate power source to maintain temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours after the loss of primary electrical power during a declared state of emergency. The plan must include information regarding fuel source and fuel storage. 1. Facilities must store minimum amounts of fuel onsite as follows: a. A facility with a licensed capacity of 16 beds or less must store 48 hours of fuel onsite. b. A facility with a licensed capacity of 17 or more beds must store 72 hours of fuel onsite. 2. An assisted living facility located in an area in a declared state of emergency area pursuant to Section 252.36, F.S. that may impact primary power delivery must secure ninety-six (96) hours of fuel. The assisted living facility may utilize portable fuel storage containers for the remaining	A 200		

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	AL11965505	A. BUILDING: _____ B. WING _____	11/09/2024

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A 200	Continued From page 29 fuel necessary for ninety-six (96) hours during the period of a declared state of emergency. 3. Piped natural gas is an allowable fuel source and meets the onsite fuel supply requirements under this rule. 4. If local ordinances or other regulations limit the amount of onsite fuel storage for the assisted living facility's location, then the assisted living facility must develop a plan that includes maximum onsite fuel storage allowable by the ordinance or regulation and a reliable method to obtain the maximum additional fuel at least 24 hours prior to depletion of onsite fuel. (c) The acquisition of services necessary to maintain, and test the equipment and its functions to ensure the safe and sufficient operation of the alternate power source maintained at the assisted living facility. (d) The acquisition and maintenance of a monoxide alarm. (2) SUBMISSION OF THE PLAN. (a) Each new assisted living facility shall submit the plan required under this rule prior to obtaining a license. (b) Each existing assisted living facility that undergoes any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of its systems or equipment affecting the facility's compliance with this rule shall amend its plan and submit it to the county emergency management agency for review and approval. (3) APPROVED PLANS. (a) Each assisted living facility must maintain a copy of its approved plan in a manner that makes the plan readily available at the licensee's physical address for review by a legally authorized entity. If the plan is maintained in an electronic format, assisted living facility staff must	A 200		

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A 200	Continued From page 30 be readily available to access and produce the plan. For purposes of this section, "readily available" means the ability to immediately produce the plan, either in electronic or paper format, upon request. (b) Within 30 days of the approval of the plan from the county emergency management agency, the assisted living facility shall submit in writing proof of the approval to the Agency for Health Care Administration to assistedliving@ahca.myflorida.com. (c) The assisted living facility shall submit a consumer-friendly summary of the emergency power plan to the Agency. The Agency shall post the summary and notice of the approval and implementation of the assisted living facility emergency power plans on its website within ten (10) business days of the plan's approval by the county emergency management agency and update within ten (10) business days of implementation. (4) IMPLEMENTATION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall, no later than . , have implemented the plan required under this rule. (b) Each new assisted living facility shall implement the plan required under this rule prior to obtaining a license. (c) Existing assisted living facilities that undergo any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of the systems or equipment affecting the assisted living facility's compliance with this rule shall implement its amended plan concurrent with any such additions, modifications, alterations, refurbishment, renovations or reconstruction. (5) POLICIES AND PROCEDURES.	A 200		

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A 200	Continued From page 31 (a) Each assisted living facility shall develop and implement written policies and procedures to ensure that the assisted living facility can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. The procedures shall ensure that residents do not experience complications from fluctuations in air temperatures inside the facility. Procedures must address the care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury including: 1. The use of cooling devices and equipment; 2. The use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration; 3. Wellness checks by assisted living facility staff to monitor for signs of , and heat injury; and 4. A provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy. (b) Each assisted living facility shall maintain the written policies and procedures in a manner that makes them readily available at the licensee's physical address for review by a legally authorized entity. If the policies and procedures are maintained in an electronic format, assisted living facility staff must be readily available to access the policies and procedures and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce the policies and procedures, either in electronic or paper format, upon request. (c) The written policies and procedures must be readily available for inspection by each resident; each resident's legal representative, designee,	A 200		

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A 200	Continued From page 32 surrogate, guardian, attorney in fact, or case manager; each resident's estate; and such additional parties as authorized in writing or by law. (6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this rule, the Agency for Health Care Administration may seek any remedy authorized by Chapter 429, Part I, or Chapter 408, Part II, F.S., including, but not limited to, license revocation, license suspension, and the imposition of administrative fines. (7) COMPREHENSIVE EMERGENCY MANAGEMENT PLAN. (a) Assisted living facilities whose comprehensive emergency management plan is to evacuate must comply with this rule. (b) Each facility whose plan has been approved shall submit the plan as an addendum with any future submissions for approval of its comprehensive emergency management plan. (8) NOTIFICATION. (a) Within five (5) business days, each assisted living facility must notify in writing, unless permission for electronic communication has been granted, each resident and the resident's legal representative: 1. Upon the initial submission of the plan to the county emergency management agency that the plan has been submitted for review and approval; 2. Upon final implementation of the plan by the assisted living facility. 3. Annual submissions and approvals of the plan do not require notification to residents or their legal representatives unless a significant modification as defined in Rule 59A-36.019, F.A.C., has been made to the plan. (b) Each assisted living facility must maintain a copy of each notification set forth in paragraph (a)	A 200		

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A 200	Continued From page 33 above in a manner that makes each notification readily available at the licensee's physical address for review by a legally authorized entity. If the notifications are maintained in an electronic format, facility staff must be readily available to access and produce the notifications. For purposes of this section, "readily available" means the ability to immediately produce the notifications, either in electronic or paper format, upon request. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure their Emergency Environmental Control Plan (EECP) was up-to-date and approved by the Broward County Emergency Management Division. The findings include: Review of the facility Emergency Environmental Control Plan (EECP) file provided on , revealed missing notification of the EECP letter approval. A review of the Local County Emergency Management Division's database on documents EECP status as under review. Further review revealed no entries or information documenting that the facility had submitted the request for an approval of their EECP. The facility was also unable to provide any information regarding their EECP. During an interview on at approximately 10:30 AM, the Administrator was informed to provide documentation of the EECP approval Plan, either in electronic or paper format, at this time the Administrator stated due to a repossession of the fixed generator in early	A 200		

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A 200	Continued From page 34 2024 (unable to provide date of the repossession) he stated EECP approval is pending. The Administrator was asked if he had reported the changes to the Local County Emergency Management Division and he stated no. He stated due to outstanding violations from the local Fire Department was unable to move forward with submission until all violations are cleared. The Administrator stated, the facility is now operating off a portable generator. During an interview on at 1:30 PM the Administrator acknowledged the findings. No additional documents were provided at the time of the survey. Class III	A 200		
A 000	Initial Comments An unannounced Relicensure, Generator Monitoring and Complaint (2024003543) was conducted on at Sun Coast Residential Care Inc. The facility had deficiencies identified related to the Relicensure, Generator Monitoring and Complaint at the time of the survey.	A 000		
A 054	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for	A 054		

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A 054	Continued From page 35 use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known ␣ the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on observation record review and interview it was determined that the facility failed to maintain a daily Medication Observation Record (MOR) for each resident receiving assistance with self-administration of medication or medication administratio, for 1 out of 1 sampled resident (Resident #1). The findings include: During a Medication Audit (medication review) conducted on this surveyor observed resident's medication available for review (Med Aduit). However, further review of the facility's records revealed no current MOR for	A 054		

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A 054	Continued From page 36 2024 available documenting that Resident #1 is receiving assistance with self-administration of medication or medication administration. During an interview on at 1:30 PM the administrator acknowledged the facility has no current MOR ( ) available for review at the time of the survey. No additional documentation was provided. Class III	A 054		
A 078	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	A 078		

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A 078	Continued From page 37 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 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:	A 078		

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A 078	Continued From page 38 Based on record review and interview, it was determined the facility failed to ensure staff had documented evidence of the annual negative ( ) for 2 of out 4 sampled Staff (Staff A and B). The findings include: Review of the facility's personnel file on Staff A (Administrator) with a hire date of . Staff A last negative annual date of . Review of the facility's personnel file on Staff B (Caregiver) with a hire date of . Staff B last negative annual date of . During an interview on at 1:30 PM the Administrator acknowledged the findings. No additional documentation was provided. Class III	A 078		
A 080	429.52( ) 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	A 080		

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A 080	Continued From page 39 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. (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	A 080		

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A 080	Continued From page 40 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 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, it was determined that the facility failed to ensure the Administrator had completed CORE training requirement of 12 hours of continuing education. The findings include:	A 080		

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A 080	Continued From page 41 During a review of the Administrator's personnel file revealed CORE Training and Exam completion date of . Further review of the personnel file revealed the last training requirement of the 12 hours of continuing education was dated . During an interview with the Administrator on at approximately 10:15 AM, he was informed to provide proof for the CORE Training continuing education for the year 2023. During an interview on at approximately 1:30 PM the Administrator stated he did not have documents readily available for review at the time of survey. He acknowledged the findings. No additional documentation was provided. Class III	A 080		

Agency for Health Care Administration

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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: 1. A person 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. 2. Effective , , , or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity. (c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse. 1. Before , , , initial status and any changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person ' s status has been made. 2. Effective , , , initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person ' s status has been made.	CZ814		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	11/09/2024

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CZ814	Continued From page 1 (d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic ˙ , submission to the Department of Law Enforcement. The registration must include the person ' 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 observation, interview and record review, it was determined that the facility failed to register employees for the Background Screening with the Clearinghouse and maintained employment status for 2 out of 4 sampled staff (Staff C and D) The findings include: This surveyor entered the facility for the biannual survey on at approximately 10:00 AM during the survey, this surveyor observed the staffing schedule posted in the common area reflecting Staff C (Caregiver) with her name on it. 1) During an interview on at approximately 10:45 AM the Administrator was informed to provide the facility personal file for Staff C. Review of the personal file revealed no documentation for the Background Screening with the Clearinghouse in her file. The	CZ814		

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CZ814	Continued From page 2 Administrator stated that at this time the facility only has one resident and therefore Staff C services are required as needed (On Call). He stated Staff C provides direct care to the residents during her shift. Review of the Background Screening Clearinghouse on revealed Staff C is not listed in the facility employee roster. 2) During an interview on at approximately 10:50 AM the Administrator was informed to provide the facility personal file for Staff D (Caregiver). The Administrator stated Staff D no longer work at the facility, he was asked to provide an end date for employment. He stated at this time he does not remember. Review of the Background Screening Clearinghouse on revealed Staff D with a hire date of and it does not reflect an end date of employment. During an interview on at approximately 1:30 PM the Administrator acknowledged the findings. No additional documentation was provided Unclassified	CZ814		
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	CZ816		

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CZ816	Continued From page 3	CZ816		

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 Enforcement to forward the person's , to the Federal Bureau of Investigation for a national criminal history record check unless the person's , are enrolled in the Federal Bureau of Investigation's national retained print notification program. If the , 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 , electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the , to the Federal Bureau of Investigation for a national criminal history record check. The , shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print 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 , . 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

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CZ816	Continued From page 4 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 (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	CZ816		

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CZ816	Continued From page 5 employer immediately if for any disqualifying offense. (e) An administrator or chief financial officer must be screened and qualified prior to , , to the position. (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, it was determined the facility did not have complete Attestation of Compliance for 1 of out 4 sampled Staff (Staff B). The findings include: Review of personnel file conducted on for Staff B (Caregiver) with a hire date of . Staff B did not have a completed Attestation form in her employee file	CZ816		

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CZ816	Continued From page 6 During an interview on at approximately 1:30 PM the administrator acknowledged the findings. No additional documentation was provided. Unclassified	CZ816		
CZ830	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for	CZ830		

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CZ830	Continued From page 7 up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be	CZ830		

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CZ830	Continued From page 8 current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure its Comprehensive Emergency Management Plan (CEMP) was up-to-date and approved by the Local County Emergency Management Division. The findings include: Review of the facility CEMP's file provided on , revealed missing notification of the facility's current CEMP approval status. It could not be determined any prior CEMP approvals. A review of the Local County Emergency Management Division's database on documented CEMP status as Draft. Further review revealed no entries or information documenting that the facility had submitted the request for an approval of their CEMP. During an interview with the Administrator on at approximately 10:15 AM the Administrator was asked to confirm if the facility has a fixed or portable generator, and he stated	CZ830		

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CZ830	Continued From page 9 due to a repossession of the fixed generator in early 2024 (unable to provide date of the repossession) he had to make some changes by replacing it with a portable generator instead. The Administrator was asked if he had reported the changes to the Local County Emergency Management Division and he stated no. He stated due to outstanding violations from the local Fire Department was unable to move forward with CEMP submission until all violations are cleared. During an interview with the Administrator on at 1:30 PM the Administrator acknowledged the findings. No additional documentation was provided. Class III	CZ830		
CZ841	408.823( ) FS In-person Visitation (1) This section applies to , 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 , , 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 control and education policies for visitors; screening, personal protective equipment, and other control protocols for visitors; permissible length of visits and	CZ841		

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CZ841	Continued From page 10 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 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 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	CZ841		

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CZ841	Continued From page 11 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 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 interview and record review, it was determined that the facility failed to meet the Florida State regulation requirements for Visitation policies and procedures that include in-person visitation guidelines. The findings include: During a relicensure survey on at approximately 10:30 AM, the Administrator was informed to provide a copy of the Visitation Policies and Procedures including in-person visitation guidelines for review. The Administrator	CZ841		

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CZ841	Continued From page 12 was asked if the facility had a website listing the vistation policy. He stated "no". Therefore, the facility was unable to demonstrate that the facility established a policy that address the following required components. a) control education for visitors. b) screening. c) PPE. d) essential caregiver designation. e) visit length (essential caregivers must be allowed visitation at least two hours daily). f) consensual physical contact g) designation of a person responsible for ensuring staff adhere to the policies and procedures. h) visitation in end-of-life situations. i) visitation for a resident, client, or patient who was living with family before being admitted to the provider's care and is struggling with the change in environment and lack of in-person family support. j) visitation in the event the resident, client, or patient is making one or more major medical decisions. k) visitation when a resident, client, or patient is experiencing emotional distress or grieving the loss of a friend or family member who recently . l) visitation when a resident, client, or patient needs cueing or encouragement to eat or drink which was previously provided by a family member or caregiver. m) visitation when a resident, client, or patient who used to talk and interact with others is seldom speaking.	CZ841		

Agency for Health Care Administration

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CZ841	Continued From page 13 During an interview on at 1:30 PM the Administrator acknowledged that, the facility did not have the Visitation policies and procedures that include in-person visitation guidelines available at the time of the survey. No additional documentation was provided. Class	CZ841		

Agency for Health Care Administration

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A 000	Initial Comments An unannounced Relicensure, Generator Monitoring and Complaint (2024003543) was conducted on at Sun Coast Residential Care Inc. The facility had deficiencies identified related to the Relicensure, Generator Monitoring and Complaint at the time of the survey.	A 000		
A 054	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section	A 054		

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A 054	Continued From page 1 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on observation record review and interview it was determined that the facility failed to maintain a daily Medication Observation Record (MOR) for each resident receiving assistance with self-administration of medication or medication administratio, for 1 out of 1 sampled resident (Resident #1). The findings include: During a Medication Audit (medication review) conducted on this surveyor observed resident's medication available for review (Med Aduit). However, further review of the facility's records revealed no current MOR for available documenting that Resident #1 is receiving assistance with self-administration of medication or medication administration. During an interview on at 1:30 PM the administrator acknowledged the facility has no current MOR ( ) available for review at the time of the survey. No additional documentation was provided. Class III	A 054		
A 078	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	A 078		

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A 078	Continued From page 2 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 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	A 078		

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A 078	Continued From page 3 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, it was determined the facility failed to ensure staff had documented evidence of the annual negative ( ) for 2 of out 4 sampled Staff (Staff A and B). The findings include: Review of the facility's personnel file on Staff A (Administrator) with a hire date of . Staff A last negative annual date of . Review of the facility's personnel file on Staff B (Caregiver) with a hire date of . Staff B last negative annual date of . During an interview on at 1:30 PM the	A 078		

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A 078	Continued From page 4 Administrator acknowledged the findings. No additional documentation was provided. Class III	A 078		
A 080	429.52( ) 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. (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	A 080		

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A 080	Continued From page 5 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 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	A 080		

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A 080	Continued From page 6 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, it was determined that the facility failed to ensure the Administrator had completed CORE training requirement of 12 hours of continuing education. The findings include: During a review of the Administrator's personnel file revealed CORE Training and Exam completion date of . Further review of the personnel file revealed the last training requirement of the 12 hours of continuing education was dated . During an interview with the Administrator on at approximately 10:15 AM, he was informed to provide proof for the CORE Training continuing education for the year 2023. During an interview on at approximately 1:30 PM the Administrator stated he did not have documents readily available for review at the time of survey. He acknowledged the findings. No additional documentation was provided.	A 080		

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A 080	Continued From page 7 Class III	A 080		
A 081	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 inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating	A 081		

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A 081	Continued From page 8 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 control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of	A 081		

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A 081	Continued From page 9 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 regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment.	A 081		

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A 081	Continued From page 10 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide documented Elopement Drills conducted twice a year, the facility failed to ensure complete Preservice Orientation (Staff In-Service Training) the facility failed to ensure staff had complete training in Nutritional and Safe Food Handling for 2 of out 4 sampled staff (Staff A and B) The findings include: 1)During review of the personnel file on for Staff B (Caregiver) with a hire date of revealed no documentation for Elopement drills for the year 2023. Further review of the file revealed no documentation of the Preservice Orientation and 1-hour training in Nutritional and Safe Food Handling in her file. During an interview with the Administrator on at approximately 10:15 AM he was informed to provide documentation for Elopement drills for the year 2023 and documentation of the Preservice Orientation for Staff B. The Administrator was asked if, Staff B prepares and serves food to the residents during her shift	A 081		

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A 081	Continued From page 11 (breakfast and Dinner) and he stated yes. During an interview with the Administrator on at approximately 10:45 AM he stated he prepares and serves food to residents when Staff B is not available. 2) During review of the personnel file on for Staff A (Administrator) with a hire date of revealed no documentation for 1-hour training in Nutritional and Safe Food Handling in his file. During an interview on at approximately 1:30 PM the Administrator stated he did not have documents readily available for review at the time of survey. He acknowledged the findings. No additional documentation was provided. Class	A 081		
A 084	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of	A 084		

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A 084	Continued From page 12 medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, , dosage forms, and , , , and dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders;	A 084		

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A 084	Continued From page 13 e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with syringes that are prefilled with the proper dosage by a pharmacist and , that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection; i. Assist with ; j. Use a to perform testing; k. Assist residents with and continuous positive airway pressure (CPAP) devices, excluding the titration of the levels; l. Apply and remove stockings and hosiery; m. Placement and removal of bags, excluding the removal of the or manipulation of the site; and, n. Measurement of rate, temperature, and rate. (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have	A 084		

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A 084	Continued From page 14 successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that staff who provide assistance with self-administration of medications had completed 2-hour continuing education training for assistance with self-administer medications for 2 out of 4 sampled staff (Staff A, and B) The findings include: During an interview with Staff A (Administrator) on at approximately 10:45 AM he stated he covers the weekend shift as live-in (24 hours) and he confirmed that he assists with self-administration of medications. The Administrator stated Staff B (Caregiver) assist with self-administration of medications Monday through Friday (Day Shift).	A 084		

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	AL11965505	A. BUILDING: _____ B. WING _____	11/09/2024

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A 084	Continued From page 15 During a record review of Staff A on 11/09/2024 with a hire date of , it was revealed that Staff A had no documentation of the required 2-hour annual training assisting with self-administration of medications for the years 2023 and 2024. The last training documented in his file is dated . Further review revealed the initial 6-hour training was not in the personnel file at the time of the survey. During a record review of Staff B on 11/09/2024 with a hire date of , it was revealed that Staff B had no documentation of the required 2-hour annual training assisting with self-administration of medications for the year 2024. The last training documented in her file is dated . Further review revealed the initial 6-hour training was not in her personnel file at the time of the survey. During an interview on at 1:30 PM the Administrator acknowledged the findings. He was given an opportunity to provide documentation to support the missing training. No additional documentation was provided. Class III	A 084		
A 085	59A-36.011(7) FAC Training - Nutrition & Food Service (7) NUTRITION AND FOOD SERVICE. The administrator or person designated by the administrator as responsible for the facility's food service and the day-to-day supervision of food service staff must obtain, annually, a minimum of 2 hours continuing education in topics pertinent to nutrition and food service in an assisted living facility. This requirement does not apply to	A 085		

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A 085	Continued From page 16 administrators and designees who are exempt from training requirements under paragraph 59A-36.012(1)(b). A certified food manager, licensed dietician, registered dietary technician or health department sanitarian is qualified to train assisted living facility staff in nutrition and food service. This Statute or Rule is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure the Administrator, or designated person responsible for the facility's Food Service had completed annual continuing education for 1 out of 4 sample staff (Staff A) The findings include: During an interview with the Administrator on at approximately 10:45 AM, he stated he is the facility's Food Service designee. The Administrator was informed to provide documentation for the Food Service continuing education. Review of the facility's personnel record on for Staff A (Administrator) with a hire date of revealed last documented continuing education for Nutrition and Food Service was dated . During an interview on at 1:30 PM the Administrator stated, he does not have documentation to support updated annual training of continuing education for Food Service. Class III	A 085		

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A 093	Continued From page 17	A 093		
A 093	59A-36.012(2) FAC Food Service - Dietary Standards (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	A 093		

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A 093	Continued From page 18 the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on 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.	A 093		

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A 093	Continued From page 19 Intervals between meals must be evenly distributed throughout the day with not less than 2 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 observation, interview and record review, it was determined that the facility failed to ensure the annual Food Menu was up to date. The Facility failed to ensure that a 3-day emergency food supply of non-perishable food was not expired at the time of the survey. The findings include: During a facility tour on between 10:00 AM and 2:00 PM, this surveyor observed an expired food menu posted on the refrigerator.	A 093		

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A 093	Continued From page 20 The menu posted showed an effective date of and an expiration date . Further observation revealed that the 3-day emergency food supply (located in the common area - hallway/storage room) had multiple expired non-perishable food items. It was noted a majority of the food had an expiration date of 2022 or 2023. At this time, the Administrator was interviewed regarding the expired food, in which he acknowledged the expiration dates. During an interview on at approximately 10:45 AM the Administrator was requested to provide the facility's current annual Food Menu. The Administrator was unable to provide a current menu for review. The only menu available was the expired menu posted on the refrigerator. During an interview on at 1:30 PM, the Administrator acknowledged the findings. Class III	A 093		
A 120	429.17(3) .275(1); 59A-36.013(1) FAC Fiscal - Financial Stability 429.17 (3) In addition to the requirements of part II of chapter 408, each facility must report to the agency any adverse court action concerning the facility's financial viability, within 7 days after its occurrence. The agency shall have access to books, records, and any other financial documents maintained by the facility to the extent necessary to determine the facility's financial stability.	A 120		

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A 120	Continued From page 21 429.275 (1) The administrator or owner of a facility shall maintain accurate business records that identify, summarize, and classify funds received and expenses disbursed and shall use written accounting procedures and a recognized accounting system. 59A-36.013 Fiscal Standards. (1) FINANCIAL STABILITY. The facility must be administered on a sound financial basis in order to ensure adequate resources to meet resident needs pursuant to the requirements of chapter 408, part II, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. This Statute or Rule is not met as evidenced by: Based on interviews, observation and record review, it was determined that the facility failed to ensure it was operating on a sound financial basis and maintaining financial stability. It was determined that the facility failed to have sufficient financial resources available to maintain the monthly payments for the facility generator and to make needed repairs. The findings Include: During an interview with the Administrator on at approximately 10:00 AM, he stated the generator was repossessed. This surveyor requested to see where the designated area for the generator was located. At this time, the Administrator provided the exact location for observations. An observation revealed the generator was located on the patio of the house, as confirmed by the Administrator. The area was noted to be without the fixed generator, it had been removed.	A 120		

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A 120	Continued From page 22 During an interview with the Administrator on at approximately 10:30 AM. He stated the generator was repossessed in early 2024 and he does not remember the exact date of the repossession. The Administrator was asked to provide an explanation as to why the generator was repossessed. The Administrator stated there are two financial components that resulted in the generator repossession. He stated the following: A) $30,000 amount for the Generator Unit, with monthly payments of $500 for 18 months to the local generator supplier/company to be paid by the facility. B) An initial $5,000 down payment that was borrowed from a financial institution (Bank/third party) for the purchase of the generator. The Administrator stated that having to pay for the generator (supplier) monthly, third party financial institution (Bank) and the local city fire department for unresolve inspections had put him on financial strain, therefore not able to make those monthly payments as scheduled on his contract. During confidential interviews on and with the local fire department and generator supplier it was determined that the facility has past invoices and unresolved violations that yield to monetary resolution, as a result of the uncorrected violations. It was also confirmed as of the date of the survey that the violations have not been corrected by the facility. During record review on of the facility's annual Fire Inspection dated revealed the following violations: 1) Hallandale Beach - Construction or work without a permit. Possible unpermitted construction or alteration. Inspector Notes: Generator removal without permit. It was advised	A 120		

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A 120	Continued From page 23 the generator company removed the generator due to non-payment: Violation found , Will be rechecked on or after , Violation not repaired. 2)Fire alarm system is required to have annual inspection: Violation found , Will be rechecked on or after , Violation not repaired. 3)Fire alarm system is in need of repair: Violation found , Will be rechecked on or after , Violation not repaired 4) Inspector Notes: Diaper not functioning properly: Violation found , Will be rechecked on or after , Violation not repaired. 5) Fire sprinkler system is required to have annual inspection: Violation found , Will be rechecked on or after , Violation not repaired. 6) Replace damaged, painted or corroded sprinkler heads: Violation found , Will be rechecked on or after , Violation not repaired. 7) Emergency power supply required: Violation found , Will be rechecked on or after , Violation not repaired. 8) Fire extinguishers need service or replacement: Violation found , Will be rechecked on or after , Violation not repaired. 9) truss sign required: Violation found , Will be rechecked on or after	A 120		

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A 120	Continued From page 24 , Violation not repaired During a record review on of the facility's generator supplier notice revealed the following: A) Invoice dated from the generator supplier with Bill To and Service To the facility's Administrator name and facility address. Total amount of $22, 267.31 / Paid $0.00 / Balance of $22,267.31 Past due. B) Letter (undated) from the generator supplier addressed to the Administrator (facility address) documented supplier had made several attempts to collect on past due amount of $22,267.31 and it was very important to get in touch with the supplier regarding balance or supplier will be forced to take further action. The undated letter was signed by the supplier's bookkeeper. C) An agreement letter dated , signed and dated by both parties (Administrator and generator supplier). The agreement letter documented the following. Balance due of $12,767.31 The following is a payment plan for the above balance due on your generator project. You agree to pay [Generator Company] the amount of $1500 per month until paid in full on the 18th of every month. During a further confidential interview, it was revealed the generator was installed in , the total cost of the generator and installation was $26,187.43. The facility made a down payment of $5237.40 plus an additional third-party financing payment of $9500 in 2022 (at the time of initial down payment). The facility stopped making payments in 2022 (last payment). The facility upon agreement in , with the	A 120		

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A 120	Continued From page 25 generator company agreed to make monthly payments of $1500(for 18 months) to ensure final payment of the outstanding balance of $12,767.31 and to bring the account current due to delinquent status. The facility made a total of 3 monthly payments (total of $4500) per the agreement, no further payments received. The final balance due before repossession was $8267.31. The generator was repossessed in . During an interview on at approximately 1:30 PM, the Administrator acknowledged he had financial hardship resulting in a repossession of the facility generator follow by unresolve violations from the local city department. Class II	A 120		
A 152	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no	A 152		

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A 152	Continued From page 26 less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that existing structural systems and appurtenances are maintained in good working order. The facility failed to provide a safe living environment for all residents that reside at the facility. The findings include: During a review of the facility's record revealed that the annual Fire Inspection dated . Further review of the inspection report revealed prompt action required by the facility for the following 18 violations as follows: 1) Emergency preparedness plan required: Violation found , Will be rechecked on	A 152		

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A 152	Continued From page 27 or after , Violation not repaired. 2) Emergency preparedness drills need to be documented: Violation found , Will be rechecked on or after , Violation not repaired. 3) Fire alarm system is required to have annual inspection: Violation found , Will be rechecked on or after , Violation not repaired. 4) Provide copy of annual fire alarm system inspection report: Violation found , Will be rechecked on or after , Violation not repaired. 5) Fire alarm inspection tag must be properly posted: Violation found , Will be rechecked on or after , Violation not repaired. 6) Fire alarm system is in need of repair: Violation found , Will be rechecked on or after , Violation not repaired. 7) Inspector Notes: Diaper not functioning properly: Violation found , Will be rechecked on or after , Violation not repaired. 8) Fire sprinkler system is required to have annual inspection: Violation found , Will be rechecked on or after , Violation not repaired. 9) Annual inspection tag must be posted: Violation found , Will be rechecked on or after , Violation not repaired.	A 152		

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A 152	Continued From page 28 10) Provide annual inspection report: Violation found , Will be rechecked on or after , Violation not repaired. 11) Replace damaged, painted or corroded sprinkler heads: Violation found , Will be rechecked on or after , Violation not repaired. 12) Emergency power supply required: Violation found , Will be rechecked on or after , Violation not repaired. 13) Fire extinguishers need service or replacement: Violation found , Will be rechecked on or after , Violation not repaired. 14) Building address must be visible: Violation found , Will be rechecked on or after , Violation not repaired. 15) Update keys in Knox box: Violation found , Will be rechecked on or after , Violation not repaired. 16) Label keys in Knox box: Violation found , Will be rechecked on or after , Violation not repaired. 17) truss sign required: Violation found , Will be rechecked on or after , Violation not repaired. 18) Hallandale Beach - Construction or work without permit. Possible unpermitted construction or alteration. Inspector Notes: Generator removal without permit. Was advised the generator company removed the generator due to non payment: Violation found , Will be rechecked on or after , Violation not	A 152		

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	AL11965505	A. BUILDING: _____ B. WING _____	11/09/2024

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A 152	Continued From page 29 repaired. During an interview on at approximately 11:00 AM, the Administrator was given an opportunity to provide documentation indicating the aforementioned violations had been corrected. The Administrator stated he has financial hardship at this time and all violations mentioned above are still pending. He was also unable to provide a date in the near future in which these items would be corrected. Class III	A 152		
A 162	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services,	A 162		

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A 162	Continued From page 30 therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A ⌣ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their ⌣ recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that ⌣ not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust	A 162		

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A 162	Continued From page 31 fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by	A 162		

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A 162	Continued From page 32 contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided 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 observation, record review and interview it was determined, the facility failed to maintain resident records on premises that include a copy of Health Assessment (AHCA Form1823), residents orders for medication, ◡ record, copy of the resident contract, nursing services or other services to be provided, supervised or implemented by the facility that require a health care provider's order for 1 out of 1 sampled resident (Resident#1). The findings include: During a tour on between 10:00 AM and 2:00 PM this surveyor observed Resident #1 in his room. During an interview on at approximately 10:00 AM, Resident #1 stated, he is and depends on staff to assist with his daily personal care. During record review of Resident#1's file revealed an AHCA Form1823 documenting another facility's name. Further review of the chart revealed no documentation of Resident #1's orders for medication, ◡ record, copy of the resident contract, nursing services or other services provided, supervised or implemented by the facility at the time of survey. During an interview on at approximately 10:45	A 162		

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A 162	Continued From page 33 AM the Administrator was informed to provide copies of the above-mentioned documents. During an interview on at 1:30 PM the Administrator acknowledged the missing documents in Resident #1's chart. No additional documentation was provided during the survey. Class III	A 162		
A 200	59A-36.025 FAC Emergency Environmental Control 59A-36.025 Emergency Environmental Control for Assisted Living Facilities. (1) DETAILED EMERGENCY ENVIRONMENTAL CONTROL PLAN. Each assisted living facility shall prepare a detailed plan ("plan") to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency environmental control in the event of the loss of primary electrical power in that assisted living facility which includes the following information: (a) The acquisition of a sufficient alternate power source such as a generator(s), maintained at the assisted living facility, to ensure that current licensees of assisted living facilities will be equipped to ensure air temperatures will be maintained at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. 1. The required temperature must be maintained in an area or areas, determined by the assisted living facility, of sufficient size to maintain residents safely at all times and that is appropriate for resident care needs and life safety requirements. For planning purposes, no less than twenty (20) net square per resident must be provided. The assisted living facility may	A 200		

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A 200	Continued From page 34 use eighty percent (80%) of its licensed bed capacity as the number of residents to be used in the . . to determine the required square footage. This may include areas that are less than the entire assisted living facility if the assisted living facility's comprehensive emergency management plan includes allowing a resident to congregate when he or she desires in portions of the building where temperatures will be maintained and includes procedures for monitoring residents for signs of heat related injury as required by this rule. This rule does not prohibit a facility from acting as a receiving provider for evacuees when the conditions stated in Section 408.821, F.S. and subsection 59A-36.019(5), F.A.C., are met. The plan shall include information regarding the area(s) within the assisted living facility where the required temperature will be maintained. 2. The alternate power source and fuel supply shall be located in an area(s) in accordance with local zoning and the Florida Building Code. 3. Each assisted living facility is unique in size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and staffing characteristics. Accordingly, this rule does not limit the types of systems or equipment that may be used to achieve temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. The plan shall include information regarding the systems and equipment that will be used by the assisted living facility and the fuel required to operate the systems and equipment. a. An assisted living facility in an evacuation zone pursuant to Chapter 252, F, S. must maintain an alternative power source and fuel as required by	A 200		

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A 200	Continued From page 35 this subsection at all times when the assisted living facility is occupied but is permitted to utilize a mobile generator(s) to enable portability if evacuation is necessary. b. Assisted living facilities located on a single campus with other facilities under common ownership, may share fuel, alternative power resources, and resident space available on the campus if such resources are sufficient to support the requirements of each facility's residents, as specified in this rule. Details regarding how resources will be shared and any necessary movement of residents must be clearly described in the emergency power plan. c. A multistory facility, whose comprehensive emergency management plan is to move residents to a higher floor during a flood or surge event, must place its alternative power source and all necessary additional equipment so it can safely operate in a location protected from flooding or storm surge damage. (b) The acquisition of sufficient fuel, and safe maintenance of that fuel at the facility, to ensure that in the event of the loss of primary electrical power there is sufficient fuel available for the alternate power source to maintain temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours after the loss of primary electrical power during a declared state of emergency. The plan must include information regarding fuel source and fuel storage. 1. Facilities must store minimum amounts of fuel onsite as follows: a. A facility with a licensed capacity of 16 beds or less must store 48 hours of fuel onsite. b. A facility with a licensed capacity of 17 or more beds must store 72 hours of fuel onsite. 2. An assisted living facility located in an area in a	A 200		

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A 200	Continued From page 36 declared state of emergency area pursuant to Section 252.36, F.S. that may impact primary power delivery must secure ninety-six (96) hours of fuel. The assisted living facility may utilize portable fuel storage containers for the remaining fuel necessary for ninety-six (96) hours during the period of a declared state of emergency. 3. Piped natural gas is an allowable fuel source and meets the onsite fuel supply requirements under this rule. 4. If local ordinances or other regulations limit the amount of onsite fuel storage for the assisted living facility's location, then the assisted living facility must develop a plan that includes maximum onsite fuel storage allowable by the ordinance or regulation and a reliable method to obtain the maximum additional fuel at least 24 hours prior to depletion of onsite fuel. (c) The acquisition of services necessary to maintain, and test the equipment and its functions to ensure the safe and sufficient operation of the alternate power source maintained at the assisted living facility. (d) The acquisition and maintenance of a monoxide alarm. (2) SUBMISSION OF THE PLAN. (a) Each new assisted living facility shall submit the plan required under this rule prior to obtaining a license. (b) Each existing assisted living facility that undergoes any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of its systems or equipment affecting the facility's compliance with this rule shall amend its plan and submit it to the county emergency management agency for review and approval. (3) APPROVED PLANS. (a) Each assisted living facility must maintain a	A 200		

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A 200	Continued From page 37 copy of its approved plan in a manner that makes the plan readily available at the licensee's physical address for review by a legally authorized entity. If the plan is maintained in an electronic format, assisted living facility staff must be readily available to access and produce the plan. For purposes of this section, "readily available" means the ability to immediately produce the plan, either in electronic or paper format, upon request. (b) Within 30 days of the approval of the plan from the county emergency management agency, the assisted living facility shall submit in writing proof of the approval to the Agency for Health Care Administration to assistedliving@ahca.myflorida.com. (c) The assisted living facility shall submit a consumer-friendly summary of the emergency power plan to the Agency. The Agency shall post the summary and notice of the approval and implementation of the assisted living facility emergency power plans on its website within ten (10) business days of the plan's approval by the county emergency management agency and update within ten (10) business days of implementation. (4) IMPLEMENTATION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall, no later than . , have implemented the plan required under this rule. (b) Each new assisted living facility shall implement the plan required under this rule prior to obtaining a license. (c) Existing assisted living facilities that undergo any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of the systems or equipment affecting the assisted living facility's compliance	A 200		

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A 200	Continued From page 38 with this rule shall implement its amended plan concurrent with any such additions, modifications, alterations, refurbishment, renovations or reconstruction. (5) POLICIES AND PROCEDURES. (a) Each assisted living facility shall develop and implement written policies and procedures to ensure that the assisted living facility can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. The procedures shall ensure that residents do not experience complications from fluctuations in air temperatures inside the facility. Procedures must address the care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury including: 1. The use of cooling devices and equipment; 2. The use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration; 3. Wellness checks by assisted living facility staff to monitor for signs of and heat injury; and 4. A provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy. (b) Each assisted living facility shall maintain the written policies and procedures in a manner that makes them readily available at the licensee's physical address for review by a legally authorized entity. If the policies and procedures are maintained in an electronic format, assisted living facility staff must be readily available to access the policies and procedures and produce the requested information. For purposes of this section, "readily available" means the ability to	A 200		

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A 200	Continued From page 39 immediately produce the policies and procedures, either in electronic or paper format, upon request. (c) The written policies and procedures must be readily available for inspection by each resident; each resident's legal representative, designee, surrogate, guardian, attorney in fact, or case manager; each resident's estate; and such additional parties as authorized in writing or by law. (6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this rule, the Agency for Health Care Administration may seek any remedy authorized by Chapter 429, Part I, or Chapter 408, Part II, F.S., including, but not limited to, license revocation, license suspension, and the imposition of administrative fines. (7) COMPREHENSIVE EMERGENCY MANAGEMENT PLAN. (a) Assisted living facilities whose comprehensive emergency management plan is to evacuate must comply with this rule. (b) Each facility whose plan has been approved shall submit the plan as an addendum with any future submissions for approval of its comprehensive emergency management plan. (8) NOTIFICATION. (a) Within five (5) business days, each assisted living facility must notify in writing, unless permission for electronic communication has been granted, each resident and the resident's legal representative: 1. Upon the initial submission of the plan to the county emergency management agency that the plan has been submitted for review and approval; 2. Upon final implementation of the plan by the assisted living facility. 3. Annual submissions and approvals of the plan do not require notification to residents or their	A 200		

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A 200	Continued From page 40 legal representatives unless a significant modification as defined in Rule 59A-36.019, F.A.C., has been made to the plan. (b) Each assisted living facility must maintain a copy of each notification set forth in paragraph (a) above in a manner that makes each notification readily available at the licensee's physical address for review by a legally authorized entity. If the notifications are maintained in an electronic format, facility staff must be readily available to access and produce the notifications. For purposes of this section, "readily available" means the ability to immediately produce the notifications, either in electronic or paper format, upon request. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure their Emergency Environmental Control Plan (EECP) was up-to-date and approved by the Broward County Emergency Management Division. The findings include: Review of the facility Emergency Environmental Control Plan (EECP) file provided on , revealed missing notification of the EECP letter approval. A review of the Local County Emergency Management Division's database on documents EECP status as under review. Further review revealed no entries or information documenting that the facility had submitted the request for an approval of their EECP. The facility was also unable to provide any information regarding their EECP. During an interview on at	A 200		

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A 200	Continued From page 41 approximately 10:30 AM, the Administrator was informed to provide documentation of the EECP approval Plan, either in electronic or paper format, at this time the Administrator stated due to a repossession of the fixed generator in early 2024 (unable to provide date of the repossession) he stated EECP approval is pending. The Administrator was asked if he had reported the changes to the Local County Emergency Management Division and he stated no. He stated due to outstanding violations from the local Fire Department was unable to move forward with submission until all violations are cleared. The Administrator stated, the facility is now operating off a portable generator. During an interview on at 1:30 PM the Administrator acknowledged the findings. No additional documents were provided at the time of the survey. Class III	A 200		

Agency for Health Care Administration

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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: 1. A person 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. 2. Effective , , , or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity. (c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse. 1. Before , , , initial status and any changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person ' s status has been made. 2. Effective , , , initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person ' s status has been made.	CZ814		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	11/09/2024

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CZ814	Continued From page 1 (d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic ˙ , submission to the Department of Law Enforcement. The registration must include the person ' 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 observation, interview and record review, it was determined that the facility failed to register employees for the Background Screening with the Clearinghouse and maintained employment status for 2 out of 4 sampled staff (Staff C and D) The findings include: This surveyor entered the facility for the biannual survey on at approximately 10:00 AM during the survey, this surveyor observed the staffing schedule posted in the common area reflecting Staff C (Caregiver) with her name on it. 1) During an interview on at approximately 10:45 AM the Administrator was informed to provide the facility personal file for Staff C. Review of the personal file revealed no documentation for the Background Screening with the Clearinghouse in her file. The	CZ814		

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CZ814	Continued From page 2 Administrator stated that at this time the facility only has one resident and therefore Staff C services are required as needed (On Call). He stated Staff C provides direct care to the residents during her shift. Review of the Background Screening Clearinghouse on revealed Staff C is not listed in the facility employee roster. 2) During an interview on at approximately 10:50 AM the Administrator was informed to provide the facility personal file for Staff D (Caregiver). The Administrator stated Staff D no longer work at the facility, he was asked to provide an end date for employment. He stated at this time he does not remember. Review of the Background Screening Clearinghouse on revealed Staff D with a hire date of and it does not reflect an end date of employment. During an interview on at approximately 1:30 PM the Administrator acknowledged the findings. No additional documentation was provided Unclassified	CZ814		
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	CZ816		

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CZ816	Continued From page 3	CZ816		

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 Enforcement to forward the person's , to the Federal Bureau of Investigation for a national criminal history record check unless the person's , are enrolled in the Federal Bureau of Investigation's national retained print notification program. If the , 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 , electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the , to the Federal Bureau of Investigation for a national criminal history record check. The , shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print 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 , . 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

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CZ816	Continued From page 4 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 (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	CZ816		

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CZ816	Continued From page 5 employer immediately if for any disqualifying offense. (e) An administrator or chief financial officer must be screened and qualified prior to , , to the position. (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, it was determined the facility did not have complete Attestation of Compliance for 1 of out 4 sampled Staff (Staff B). The findings include: Review of personnel file conducted on for Staff B (Caregiver) with a hire date of . Staff B did not have a completed Attestation form in her employee file	CZ816		

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CZ816	Continued From page 6 During an interview on at approximately 1:30 PM the administrator acknowledged the findings. No additional documentation was provided. Unclassified	CZ816		
CZ830	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for	CZ830		

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CZ830	Continued From page 7 up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be	CZ830		

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CZ830	Continued From page 8 current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure its Comprehensive Emergency Management Plan (CEMP) was up-to-date and approved by the Local County Emergency Management Division. The findings include: Review of the facility CEMP's file provided on , revealed missing notification of the facility's current CEMP approval status. It could not be determined any prior CEMP approvals. A review of the Local County Emergency Management Division's database on documented CEMP status as Draft. Further review revealed no entries or information documenting that the facility had submitted the request for an approval of their CEMP. During an interview with the Administrator on at approximately 10:15 AM the Administrator was asked to confirm if the facility has a fixed or portable generator, and he stated	CZ830		

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CZ830	Continued From page 9 due to a repossession of the fixed generator in early 2024 (unable to provide date of the repossession) he had to make some changes by replacing it with a portable generator instead. The Administrator was asked if he had reported the changes to the Local County Emergency Management Division and he stated no. He stated due to outstanding violations from the local Fire Department was unable to move forward with CEMP submission until all violations are cleared. During an interview with the Administrator on at 1:30 PM the Administrator acknowledged the findings. No additional documentation was provided. Class III	CZ830		
CZ841	408.823( ) FS In-person Visitation (1) This section applies to , 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 , , 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 control and education policies for visitors; screening, personal protective equipment, and other control protocols for visitors; permissible length of visits and	CZ841		

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CZ841	Continued From page 10 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 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 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	CZ841		

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CZ841	Continued From page 11 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 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 interview and record review, it was determined that the facility failed to meet the Florida State regulation requirements for Visitation policies and procedures that include in-person visitation guidelines. The findings include: During a relicensure survey on at approximately 10:30 AM, the Administrator was informed to provide a copy of the Visitation Policies and Procedures including in-person visitation guidelines for review. The Administrator	CZ841		

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CZ841	Continued From page 12 was asked if the facility had a website listing the vistation policy. He stated "no". Therefore, the facility was unable to demonstrate that the facility established a policy that address the following required components. a) control education for visitors. b) screening. c) PPE. d) essential caregiver designation. e) visit length (essential caregivers must be allowed visitation at least two hours daily). f) consensual physical contact g) designation of a person responsible for ensuring staff adhere to the policies and procedures. h) visitation in end-of-life situations. i) visitation for a resident, client, or patient who was living with family before being admitted to the provider's care and is struggling with the change in environment and lack of in-person family support. j) visitation in the event the resident, client, or patient is making one or more major medical decisions. k) visitation when a resident, client, or patient is experiencing emotional distress or grieving the loss of a friend or family member who recently . l) visitation when a resident, client, or patient needs cueing or encouragement to eat or drink which was previously provided by a family member or caregiver. m) visitation when a resident, client, or patient who used to talk and interact with others is seldom speaking.	CZ841		

Agency for Health Care Administration

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CZ841	Continued From page 13 During an interview on at 1:30 PM the Administrator acknowledged that, the facility did not have the Visitation policies and procedures that include in-person visitation guidelines available at the time of the survey. No additional documentation was provided. Class	CZ841		