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
	AL11969818	A. BUILDING: _____ B. WING _____	07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUXE SENIOR LIVING AT JUPITER	650 656 PIONEER RD JUPITER, FL 33458

(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
ZZ814	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.	ZZ814		

AHCA Form 3020-0001

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

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ZZ814	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 ˬ , 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 record review and interview, the facility failed to ensure the facility's Administrator was listed on the Background Screening Clearinghouse Roster. The findings included: A review of the facility's Background Screening Clearinghouse Employee Roster on and again on revealed the facility's Administrator was not listed on the facility employee roster. The Administrator was listed as a "requested" under the facility roster Users but did not appear when searched on the Employee Roster. On at 5:55 PM, the Human Resource Manager stated the Administrator was on the facility employee roster but when it was explained that the Administrator only appeared a "requested" the Human Resources Manager	ZZ814		

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ZZ814	Continued From page 2 stated "oh". Unclassified	ZZ814		
ZZ875	430.5025(4 &) / ; Training (4) Employees of covered providers must complete the following training for 's and related forms of : (a) Upon beginning employment, each employee must receive basic written information about interacting with persons who have 's or related forms of . (b) Within 30 days after beginning employment, each employee who provides personal care to or has regular contact with participants, patients, or residents must complete a 1-hour training program provided by the department. 1. The department shall provide training that is available online at no cost. The 1-hour training program shall contain information on understanding the basics about the most common forms of , how to identify the signs and symptoms of , and skills for communicating and interacting with persons with ' s or related forms of . A record of the completion of the training program must be made available to the covered provider which identifies the training curricula, the name of the employee, and the date of completion. 2. A covered provider must maintain a record of the employee's completion of the training program and, upon written request of the employee, provide the employee with a copy of the record of completion consistent with the employer's written policies. 3. An employee who has completed the training	ZZ875		

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ZZ875	Continued From page 3	ZZ875		

required in this subsection is not required to repeat the program upon changing employment to a different covered provider.
(c) Within 7 months after beginning employment for a home health agency, nurse registry, or companion or homemaker service provider, each employee who provides personal care must complete 2 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person ' s independence in activities of daily living, and skills in working with families and caregivers.
(d) Within 7 months after beginning employment for a nursing home, an assisted living facility, an adult family-care home, or an adult day care center, each employee who provides personal care must complete 3 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, skills in working with families and caregivers, group and individual activities, maintaining an appropriate environment, and ethical issues.
(e) For an assisted living facility, adult family-care home, or adult day care center that advertises and provides, or is designated to provide, specialized care for persons with 's or related forms of , in addition to the training specified in paragraphs (a) and (b), employees must receive the following training:
1. Within 3 months after beginning employment, each employee who provides personal care to or has regular contact with the residents or participants must complete the additional 3 hours of training as provided in paragraph (d).
2. Within 6 months after beginning employment, each employee who provides personal care must

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ZZ875	Continued From page 4	ZZ875		

complete an additional 4 hours of -specific training. Such training must include, but is not limited to, understanding and related forms of , the stages of 's , communication strategies, medical information, and stress management.
3. Thereafter, each employee who provides personal care must participate in at least 4 hours of continuing education each calendar year through contact hours, on-the-job training, or electronic learning . For this subparagraph, the term "on-the-job training" means a form of direct coaching in which a facility administrator or his or her designee instructs an employee who provides personal care with guidance, support, or -on experience to help develop and refine the employee's skills for caring for a person with 's or a related form of . The continuing education must cover at least one of the topics included in the -specific training in which the employee has not received previous training in the previous calendar year. The continuing education may be fulfilled and documented in a minimum of one quarter-hour increments through on-the-job training of the employee by a facility administrator or his or her designee or by an electronic learning chosen by the facility administrator. On-the-job training may not account for more than 2 hours of continuing education each calendar year.
(f)1. An employee provided, assigned, or referred by a health care services pool must complete the training required in paragraph (c), paragraph (d), or paragraph (e) that is applicable to the covered provider and the position in which the employee will be working. The documentation verifying the completed training and continuing education of

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ZZ875	Continued From page 5 the employee, if applicable, must be provided to the covered provider upon request. 2. A health care services pool must verify and maintain documentation as required under s. 400.980(5) before providing, assigning, or referring an employee to a covered provider. (7) For a certified nursing assistant as defined in s. 464.201, training hours completed as required under this section may count toward the total hours of training required to maintain certification as a nursing assistant. (8) For a health care practitioner as defined in s. 456.001, training hours completed as required under this section may count toward the total hours of continuing education required by that practitioner's licensing board. (9) Each person employed, , or referred to provide services before , , must complete the training required in this section before , . Proof of completion of equivalent training completed before , , shall substitute for the training required in subsection (4). Each person employed, , or referred to provide services on or after , , , may complete training using approved curriculum under paragraph (5)(d) until the effective date of the rules adopted by the department under subsection (6). This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 2 of 3 staff records reviewed (Staff A and B) maintained training records related to 's or related (ADRD). The findings included: A review of Staff A and Staff B employee records	ZZ875		

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ZZ875	Continued From page 6 was missing documentation that written information related to ADRD was provided upon employment, 1-hour training video was completed, and continuing education requirements were completed. An interview was conducted on at 4:00 PM with the Director of Nursing (SNF), confirmed the findings and stated that she would provide the documents. No documents were provided during the survey. Class III	ZZ875		

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A 000	Initial Comments An unannounced Abbreviated Relicensure, Extended Congregate Care (ECC), Complaint (# 2025003229, #2025007821 and #2025008568) and a Generator Monitoring survey, in conjunction with a revisit survey (survey date) was conducted on at Luxe Senior Living at Jupiter. Deficient practice was identified on the date of the survey.	A 000		
A 004	59A-36.004 FAC Licensure - Requirements 59A-36.004 License Requirements. (1) SERVICE PROHIBITION. An assisted living facility may not represent that it provides any service other than a service for which it is licensed to provide. (2) CHANGE IN USE OF SPACE REQUIRING AGENCY CENTRAL OFFICE APPROVAL. A change in the use of space that increases or decreases a facility's capacity must not be made without prior approval from the Agency Central Office. Approval must be based on the compliance with the physical plant standards provided in Rule 59A-36.014, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation inspection requirements referenced in Rule 59A-36.005, F.A.C. (3) CHANGE IN USE OF SPACE REQUIRING AGENCY FIELD OFFICE APPROVAL. A change in the use of space that involves converting an area to resident use, which has not previously been inspected for such use, must not be made without prior approval from the Agency Field Office. Approval must be based on compliance with the physical plant standards provided in Rule 59A-36.014, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation inspection standards referenced in Rule 59A-36.005, F.A.C.	A 004		

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A 004	Continued From page 1 (4) CONTIGUOUS PROPERTY. If a facility consists of more than one building, all buildings included under a single license must be on contiguous property. "Contiguous property" means property under the same ownership separated by no more than a two-lane street that traverses the property. A licensed location may be expanded to include additional contiguous property with the approval of the agency to ensure continued compliance with the requirements and standards of Chapters 408, Part II, 429, Part I, F.S. and rule Chapter 59A-35, F.A.C., and this rule chapter. (5) PROOF OF INSPECTIONS. A copy of the annual fire safety and sanitation inspections described in Rule 59A-36.005, F.A.C., must be submitted annually to the Agency Central Office. The annual inspections must be submitted no later than 30 calendar days after the inspections. Failure to comply with this requirement may result in administrative action pursuant to Chapter 408, part II, and Section 429.14, F.S., and rule Chapter 59A-35, F.A.C. (6) RESIDENTS RECEIVING STATE-FUNDED SERVICES. Upon request, the facility administrator or designee must identify residents receiving state-funded services to the agency and the department for monitoring purposes authorized by state and federal laws. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain required annual health inspections. The findings included: An attempted review of the annual group care health inspection was conducted on .	A 004		

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A 004	Continued From page 2 On a copy of the annual group care health inspection was requested for review. An interview was conducted on at 4:00 PM with the Director of Nursing (SNF), confirmed the document provided was for the facility kitchen inspection and not the group care inspection. The group care inspection was not provided during the survey. Class III	A 004		
A 030	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida,	A 030		

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A 030	Continued From page 3 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d),	A 030		

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A 030	Continued From page 4 F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence,	A 030		

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A 030	Continued From page 5 autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency	A 030		

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A 030	Continued From page 6 relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names	A 030		

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LUXE SENIOR LIVING AT JUPITER	650 656 PIONEER RD JUPITER, FL 33458

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A 030	Continued From page 7 and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and . Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated . or . under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation, interview and records review, the facility failed to ensure that residents lived in an environment free from neglect. The failed to ensure that all residents was provided	A 030		

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A 030	Continued From page 8 with adequate and appropriate healthcare services. The facility's lack of implementation of adequate health care services placed residents at risk of harm and/or injury. The findings included: On at 7:05 AM, an interview was conducted with Staff D. Staff D stated when a resident activates their call bell staff should respond in no more than an hour from when the resident called for assistance. On at 7:00 AM, an interview was conducted with Staff A. Staff A stated the there was no call bell system in Memory Care Unit and she has to leave the second floor of the main building where the nurse's station is and go to the Memory Care unit to do rounds at night. In an emergency staff must use their personal cell phones to call the nurse and also yell out for help. There's not always another staff immediately available or around to assist in an emergency. On , a call bell activation test were completed and determined the call bell systems was partially operational. On at 8:00 AM, an interview conducted with Staff F who stated that the call bell system in memory care Unit A is not functional. She stated there is only one staff per memory care unit plus a floating medication technician. She stated that the ineffective systems makes her very uncomfortable and it is unsafe. On at 10:13 AM, an interview with Resident #2 revealed that Resident #2 had a substantial with injury and sustained extensive , and , to her and .	A 030		

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A 030	Continued From page 9 Resident #2 stated she last night ( ) in her bathroom. Resident #2 stated she pulled her call bell in her bathroom, but it did not work. She stated she was on the floor for an hour and there was a lot of . She stated she kept calling for help, but no one could hear her. Stated eventually, one of the aides came to bring her medications and found her and sent her to the hospital and she returned at 6:00 AM that morning. On at 10:30 AM, an interview was conducted with the Director of Nursing (DON). The DON reported she was made aware by the night nurse at 11:32 PM last night ( ) that Resident #2 had a with a lump on her forehead with and and was taken to the hospital in West Palm Beach because of the . The DON stated she has not had a chance to look at the shift report and had not had a chance to see Resident #2 this morning. At 10:46 AM the DON observed and tested Resident #2's call bells and stated she was unaware that the call bells in Resident #2's room were not working. On at 12:31 PM, an interview was conducted with Resident #1 who reported there is no supervision at the facility. Resident #1 stated, they don't answer the call bells. Resident #1 stated he can't walk and uses a wheelchair. He lost balance a few weeks ago and hit his on the drawers in his room and it took them an hour and a half to come. Resident #1 reported in the last couple of weeks he's seen staff only when they bring medications and food. It's been like 10 days since someone helped me with a shower. He had to do his own showers but was afraid and did not want to . Resident #1 stated her uses a plastic , but the staff only come in to change	A 030		

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A 030	Continued From page 10 it in the morning. It gets close to overflowing at night. On at 3:00 PM, an interview was conducted with the DON who stated that she was informed by "corporate" staff that resident #4 was being transferred to her facility. She stated that she did not conduct a -to- assessment but conducted a "virtual" assessment. She stated that she did not realize the resident's care needs until he arrived at the facility. She stated he was admitted on around 4PM and stayed less than a day. He had a , . She stated the resident complained that he couldn't sit up without assistance with a hospital bed. DON stated that the resident should have been admitted to the facility rehab unit and was not appropriate for the memory care unit. DON acknowledged that the memory care call emergency bell system was ineffective. The DON stated the nurses were constantly running and forth from the main building to the memory care building because the memory care residents were the most fragile. Class II	A 030		
A 032	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar	A 032		

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A 032	Continued From page 11 days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including	A 032		

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A 032	Continued From page 12 specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation verifying elopement drill participation by direct care staff and administrator. The findings included: An attempt to review the facility elopements drills was attempted on . . . An interview was conducted on at 4:00 PM with the Director of Nursing (SNF), confirmed the document provided was the incorrect document and stated that she would provide the correct elopement drill document. No documents were provided during the survey. Class III	A 032		
A 053	59A-36.008(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION. (a) For facilities that provide medication administration, a staff member licensed to administer medications must be available to	A 053		

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A 053	Continued From page 13 administer medications in accordance with a health care provider's order or prescription label. (b) Unusual reactions to the medication or a significant change in the resident's health or behavior that may be caused by the medication must be documented in the resident's record and reported immediately to the resident's health care provider. The contact with the health care provider must also be documented in the resident's record. (c) Medication administration includes conducting any examination or other procedure necessary for the proper administration of medication that the resident cannot conduct personally and that can be performed by licensed staff. (d) A facility that performs clinical laboratory tests for residents, including ⌄ testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Chapter 483, Part I, F.S. A valid copy of the federal CLIA Certificate must be maintained in the facility. A federal CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a federal CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents' equipment. Information about the federal CLIA Certificate is available from the Laboratory and In-Home Services Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)412-4500. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure that unlicensed staff only provided assistance with self-administration of medications. The facility	A 053		

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A 053	Continued From page 14 failed to have licensed personnel administer medications to 3 of 3 sampled residents, (Residents #5, #6 and #7) who reside on the memory care unit. The findings included: Review of Resident #5's medical record indicated the resident resides in the facility's memory care unit. Review of Resident #5's current Resident Health Assessment,1823, dated indicated that the resident has , is alert, and oriented to name with . The form further indicated that the resident needs assistance with self-administration of medications. In an observation on at 8 AM of unlicensed staff assistance with self-administration of medications for Resident #5, Staff B prepared the prescribed medication for the resident. Staff B dispensed several tablets from the prepackaged pharmacy containers into a small cup and approached Resident#1 calling his name. Staff B stated, "resident's name, open your , and , here are your medications". The resident was observed and did not respond or open his , . Staff B was not observed to follow regulatory training requirements to assist with self-administration of medications including orally advising the resident of his medications. Review of Resident #6's medical record indicated the resident resides in the facility's memory care unit and is an elopement risk. Review of Resident #6's current Resident Health Assessment, 1823 form dated indicated that the resident has and , . The form further indicated that the resident needs	A 053		

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A 053	Continued From page 15 assistance with self-administration of medications. In an observation on at 8:15 AM of unlicensed staff assistance with self-administration of medications for Resident #6, Staff B prepared the prescribed medication for the resident. Staff B dispensed several tablets from the prepackaged pharmacy containers into a small cup and approached the resident calling her name. Staff B stated, "here I have your medications" and handed the small cup to resident, who then lifted the cup to her , swallowing the medications then drank water. Staff B was not observed to follow regulatory training requirements to assist with self-administration of medications including orally advising the resident of her medications. Review of Resident #7 's medical record indicated the resident resides in the facility's memory care unit. Review of Resident #7's current Resident Health Assessment, 1823 form dated indicated that the resident has and communication . Further review indicated that the resident required medication administration. In an observation on at 8:35 AM of unlicensed staff assistance with self-administration of medications for Resident #7, Staff B prepared the prescribed medication for the resident. Staff #B dispensed several tablets from the prepackaged pharmacy containers into a small cup and approached Resident #7 calling her name. Staff B stated, "here are your medications" lifted the cup to the resident's . The resident swallowed the medications and then drank water. Staff #B was not observed to follow regulatory training	A 053		

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A 053	Continued From page 16 requirements to assist with self-administration of medications including orally advising the resident of her medications. In an interview with the Director of Nursing on at approximately 4 PM she confirmed that Resident #5, #6 and #7 all currently resided in the memory care unit based on assessed needs for additional oversight due to their diagnosed medical conditions. She confirmed that they all were physically able to swallow their prescribed medications but would be unable to express what/why medications had been prescribed. She stated that the unlicensed staff was administering the medications to the residents on the memory care unit. She confirmed that the Resident Health Assessment forms for Residents #5 and #6 were not accurately reflective of the residents' current medication needs and the level of care being provided to them. She confirmed that Staff B was not a licensed nurse therefore not allowed to administer medications. Class III	A 053		
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	A 078		

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A 078	Continued From page 17 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 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	A 078		

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A 078	Continued From page 18 and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure direct care staff-maintained documentation in the employee records related to communicable and ( ) clearance annual for 3 of 3 reviewed staff (Staff A, B, C). The findings included: A review of Staff A and Staff C employee files revealed no evidence of annual clearance. A review of Staff B's employee file revealed no evidence of obtaining a communicable statement or an annual clearance. Staff A was hired on , Staff B was hired on and Staff C was hired on . An interview was conducted on at 4:00 PM with the Director of Nursing for the Skilled Nursing Facility, confirmed the findings and stated that she would provide the documents. No documents were provided during the survey.	A 078		

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A 078	Continued From page 19 Class III	A 078		
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	A 081		

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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 081	Continued From page 20 training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of	A 081		

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A 081	Continued From page 21 compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty	A 081		

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A 081	Continued From page 22 (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure direct care staff obtained the required in-services training of hire for 3 of 3 staff records reviewed (Staff A, B and C). The findings included: A review of Staff A and Staff C employee records was missing documentation that the following trainings were obtained: Elopement Response Training and Nutritional & Safe Food Handling A review of Staff B employee records was missing documentation that the following trainings were obtained: Preservice Orientation, Control Training, Elopement Response Training, Reporting Major/Adverse Incidents, Facility Emergency Procedures, Incident Reporting Training, Resident Rights and Recognizing/Reporting /Neglect Training. Staff A was hired on , Staff B was hired on and Staff C was hired on .	A 081		

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A 081	Continued From page 23 An interview was conducted on at 4:00 PM with the Director of Nursing for the Skilled Nursing Facility, confirmed the findings and stated that she would provide the documents. No documents were provided during the survey. Class III	A 081		
A 082	59A-36.011(4) FAC Training - / (4) / (/). Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on and , including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 1 of 3 (Staff B) reviewed staff records contained verification of / (/) training withing 30 days of hire. The findings included: A review of Staff B employee records was missing documentation that /) training was obtained. An interview was conducted on at 4:00	A 082		

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A 082	Continued From page 24 PM with the Director of Nursing for the Skilled Nursing Facility, confirmed the findings and stated that she would provide the documents. No documents were provided during the survey. Class III	A 082		
A 083	59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND ( ). A staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 3 of 3 staff records reviewed (Staff A, B, C) reviewed staff records containing verification of First Aid Training completion.	A 083		

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A 083	Continued From page 25 The findings included: A review of Staff A, Staff B and Staff C employee records was missing documentation that First Aid Training was obtained. An interview was conducted on at 4:00 PM with the Director of Nursing for the Skilled Nursing Facility, confirmed the findings and stated that she would provide the documents. No documents were provided during the survey. Class III	A 083		
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; 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	A 084		

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A 084	Continued From page 26	A 084		

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 reactions;
h. Assist residents with syringes that are prefilled with the proper dosage by a pharmacist and , that are prefilled by the

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A 084	Continued From page 27 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 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.	A 084		

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A 084	Continued From page 28 429.52 (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 the facility failed to ensure 3 of 3 staff records reviewed (Staff A, B, C) maintained training related to assisting with self-administration of medication and medication training updates. The findings included: A review of Staff A, Staff B and Staff C employee records was missing documentation that self-administration of medication training and medication training updates where either obtained or current. All three staff were identified as medication technicians in the employee record. An interview was conducted on at 4:00 PM with the Director of Nursing for the Skilled Nursing Facility, confirmed the findings and stated that she would provide the documents. No documents were provided during the survey. Class III	A 084		
A 090	59A-36.011(11) FAC Training -	A 090		

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A 090	Continued From page 29 (11) TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 3 of 3 staff records reviewed (Staff A, B, C) maintained training related to one hour of ( ) Training. The findings included: A review of Staff A, Staff B and Staff C employee records was missing documentation that ( ) Training was obtained. The training records located in the files revealed the trainings obtained by Staff A, B and C were 30 minutes in length. An interview was conducted on at 4:00 PM with the Director of Nursing for the Skilled Nursing Facility, confirmed the findings and stated that she would provide the documents. No documents were provided during the survey.	A 090		

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A 090	Continued From page 30 Class III	A 090		
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	A 093		

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A 093	Continued From page 31 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, 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	A 093		

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A 093	Continued From page 32 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, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of ˬ the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on , , (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observations and interview, the facility failed to ensure that food service dietary standards were maintained. The facility failed to ensure planned menus were posted or available for resident review. The facility also failed to ensure that substitutions were kept on file for six months. The findings included:	A 093		

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A 093	Continued From page 33 On throughout the survey between 7:00 AM and 5:00 PM, no menus were observed in Memory Care Building. A record review was conducted of the substitution log provided revealed the log was created in , and listed substitution from , , to current. On at 1:40 PM, an interview was conducted with Dietary Manager 1 who stated that the only substitution log available was the one provided beginning on , , . Class III	A 093		
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,	A 152		

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A 152	Continued From page 34 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 observation, interview and record review, the facility failed to provide a safe living environment by ensuring that all mechanical and electrical systems were maintained in good working order. The facility failure to maintain these systems placed residents at risk of substantial harm. The findings included: On at 7:00 AM, a tour was conducted in the memory care building Unit A. Observed two large portable air conditioning units placed in Memory Care Unit A kitchen area. Hoses attached to sink for drainage, temperature on units indicated at 67F and 71F at 7:30 AM. Small portable fans were blowing on floor in main hallway of unit. Resident rooms observed with portable air conditioning units with exhaust hoses out of a window. Three resident rooms	A 152		

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	AL11969818	A. BUILDING: _____ B. WING _____	07/15/2025

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A 152	Continued From page 35	A 152		

were vacant, A110-hot, no air conditioning unit observed. A108-vacant, air-conditioning unit running; A105 vacant, air-conditioning unit running . Observed resident census in Unit A with eight residents and Unit B with 3 residents.

On at 7:00 AM, an interview was conducted with Staff A. Staff A stated the memory care unit A did not have operational call bells in all the resident rooms. Staff A stated that staff must use their own personal cell phones to call for help in an emergency. The nurse does not stay in Memory Care building. During the night shift, one aide is assigned per unit and a medication technician floats between the units.

On at 7:15 AM, an interview with Staff B who stated she was unaware how the air conditioner has been broken or when it will be fixed. Some residents had to be moved to Memory Care Unit B because the broken air conditioning and Unit B air conditioning was working.

On at 8:00 AM, an interview conducted with Staff F who stated that the call bell system in memory care Unit A is not functional. She stated that in an emergency she must use her own cell phone to call for assistance. She stated the nurse may not be able to come quickly; there is only one staff per memory care unit plus a med technician. She stated that the ineffective system makes her very uncomfortable and it is unsafe.

On at 8:40 AM, a call bell test activation was conducted from the memory care unit A for . Observed the call bells boxes on the walls without an attached floor length red pull cord. The call bell systems were activated by pulling a red tab at the bottom of the

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A 152	Continued From page 36 call bell box. The Assistant Administrator (SNF) and Director of Nursing (SNF) were in attendance. The Assistant Administrator (SNF) stated that all call bells alerts appear on the computers located on the medication carts, the concierge's desks in the main assisted living building and the memory care building. When the surveyor and staff went to the memory care concierge desk, there was no staff at the desk and the Assistant Administrator (SNF) was unable to log on to the computer to access the call bell alert systems. The surveyor and facility staff then walked to the main assisted living building and met with the concierge attendant who reported that she only saw an alert for room A101 on her computer. On at 8:50 AM, an interview was conducted with the Maintenance Director. The Maintenance Director stated he was unaware of when the air conditioning unit went down and did not have any documentation of when the unit went down or the facility contacting a third party to fix the unit. Stated the unit went down within a month of installation and they are waiting for replacement parts to complete the repairs. The Maintenance Director stated he was not familiar with the facility code alert system (call bell) and did not know that it was not working. On at 9:15 AM, an interview with Resident #8 revealed that the air conditioners are not working in a few of the rooms on the second floor and also in the gym on the second floor. During the interview, it was observed that the current temperature was 79 degrees Fahrenheit. On at 10:13 AM, an interview with Resident #2 revealed that one of her friends in the building did not have a working air conditioner	A 152		

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A 152	Continued From page 37 in her room. Resident #2 was observed with extensive ˬ and ˬ to her and . Resident #2 stated she last night ( ) in her bathroom. Resident #2 stated she pulled her call bell in her bathroom, but it did not work. She stated she was on the floor for an hour and there was a lot of . She stated she kept calling for help, but no one could hear her. Stated eventually one of the aides came to bring her medications and found her and sent her to the hospital, she returned early this morning at 6:00 AM. On at 10:18 AM, a call bell activation test was completed in Resident #2's bathroom. This call bell system was observed to have a red and blue pull strings hanging from the box to the floor. At 10:31 AM, there was no response by facility staff. At 10:30 AM an interview was conducted with the DON who stated she had access to the call bell systems alerts. The surveyor asked her to pull up the alerts and determine if room belonging to Resident #2 was alerted in the systems. The DON stated the call bell alert for Resident #2's room is not showing on the computer. At 10:46 AM, the surveyor and the DON returned to Resident #2's room and the DON checked the call bell systems for Resident #2's bathroom and bedroom. The DON stated neither the bathroom nor the room system was working and both were in alert mode. The DON stated maintenance would normally do an audit and they should have logs. Audit logs and reports were requested, no logs or audit reports were provided during the survey. On at 10:30 AM, an interview with Resident #10 revealed that it was noticed that the air conditioner was not working on the second floor in several rooms.	A 152		

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A 152	Continued From page 38 On at 10:53 AM, an interview with Resident #3 revealed that several residents on the second floor had fans in their rooms because the air conditioner did not work. Resident #3 reported that it has been three months since the air conditioner has been down. Resident #3 reported that some residents had to stop using the exercise room on the second floor because it was too hot. On at 11:35 AM, a tour of the second-floor main assisted living building revealed that some of the resident's rooms were using a portable air conditioning unit and/or an oscillating floor fan. The observed rooms were observed to have elevated room temperatures. . . were observed to have thermostat readings of 80 degrees Fahrenheit. An oscillating floor fan was observed in . was observed at 11:40 AM to have a thermostat reading of 82 degrees Fahrenheit. A follow up observation was conducted at 11:45 AM and the thermostat for was reading 81 degrees Fahrenheit. (Photographic evidence obtained). On at 3:00 PM, an interview was conducted with the Director of Nursing (DON). The DON acknowledged that the memory care call emergency bell system was ineffective. She acknowledged that the memory care residents would not be capable of using the call bell system. She stated that the staff had to use their own cell phones to call for assistance in an emergency. Class II	A 152		

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A 165	Continued From page 39	A 165		
A 165	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse	A 165		

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incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident.
(4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident.
(6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415.
(7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply.
(8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a

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A 165	Continued From page 41 licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to report 3 of 3 adverse incidents reviewed. The findings included: On and again on the Agency Adverse Incident Reporting Systems (AIRS) was reviewed. The facility's last reported AIRS report was reported on . On at 10:13 AM, an interview was conducted with Resident #2 who reported having a in her bathroom the night of . Resident #2 reported she was sent to the hospital for care and treatment. Resident #2 was observed with extensive and and during the interview. On at 10:30 AM, an interview was conducted with the Director of Nursing (DON), regarding Resident #2's and injury. The DON confirmed it was reported to her that Resident #2 had a with a lump on forehead with and and was taken to the hospital	A 165		

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A 165	Continued From page 42 because of the . On at 12:31 PM, an interview was conducted with Resident #1 who reported he had a three weeks ago. Resident #1 stated he lost his balance in his room and and hit his on drawers. He was on his arm. Resident #1 stated he was not sent out to the hospital for a day or two after the but the next day the facility nurse came to check on him. On , a record review was regarding Resident #1's . An incident note dated , notes Resident #1 has a on and reported it on . Progress notes: , "resident requested due to on /2205." 16:04, "LATE ENTRY, per recommendation of resident PCP, resident sent to [hospital] due to 3+ pitting and , ". 22:24, "post follow up: resident returned from the hospital around 8:50 PM related to previous . Resident was given new medications with discharge papers from the ER." On , a closed record review was completed of Resident #4. A review of facility's investigative documentation (interviews) of events revealed that on at 4:00 AM Nurse received call from Emergency Management Services that a call was received from a resident inside the facility. 4:00AM [Staff A] and [Staff C] were sitting in Unit A, when police and an ambulance arrived. The resident had called 911 for assistance. 4:30AM Resident transferred to [hospital] for evaluation. Review of an interview record of Resident #4 on at 8:15 PM conducted by DON. The resident stated he needed a hospital bed and also was concerned he could not sit up to eat or drink. He stated he	A 165		

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A 165	Continued From page 43 began to experience , and became thirsty. He stated the combination of feeling like he would remain in the wrong location indefinitely, his , feeling thirsty and not seeing any assistance outside his apartment led him to call 911. On at 4:00 PM, the DON stated no adverse incident was completed or submitted for this incident. On at 4:30 PM, an adverse incident log was requested but not provided by the facility. Class III	A 165		
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	A 200		

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A 200	Continued From page 44 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 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	A 200		

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A 200	Continued From page 45 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 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	A 200		

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A 200	Continued From page 46 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 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	A 200		

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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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969818	A. BUILDING: _____ B. WING _____	07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUXE SENIOR LIVING AT JUPITER	650 656 PIONEER RD JUPITER, FL 33458

(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 48 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) 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	A 200		

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A 200	Continued From page 49	A 200		

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, 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

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A 200	Continued From page 50 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) 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 an attempted record review and interview, the facility failed to have a detailed Emergency Environmental Control Plan available for review. The findings included: On a copy of the Emergency Environmental Control Plan was requested for review. An interview was conducted on at 4:00 PM with the Assistant Administrator who stated the document was submitted for approval and provided a print out of email communication between the Administrator and the local emergency management office that note, that the	A 200		

Agency for Health Care Administration

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A 200	Continued From page 51 facility was rejected and a revised plan was never submitted to the local emergency management office. Class III	A 200		