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
	AL11966133	A. BUILDING: _____ B. WING _____	10/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY OAK PALM BEACH COUNTY	6026 OLD CONGRESS LANTANA, FL 33462

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced Complaint survey, #2024016022, #2024014058, and #2024006643, was conducted at Cherry Oak Palm Beach County on through . The facility had deficiencies at the time of the visit.	A 000		
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, 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	A 030		

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A 030	Continued From page 1	A 030		

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), 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

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A 030	Continued From page 2 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, 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	A 030		

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A 030	Continued From page 3 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 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	A 030		

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A 030	Continued From page 4 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 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	A 030		

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A 030	Continued From page 5 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 and interviews, the facility failed to ensure that residents were treated with respect and dignity during lunch service in 2 of 2 dining rooms (main dining room and dining #2). The findings included: On , an observation conducted in the main dining room of the facility between 4:30 PM to 5:45 PM revealed the residents started lining	A 030		

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A 030	Continued From page 6 up for lunch around 04:30 PM. At 5:05 PM when the doors of the dining room were opened and residents were allowed to enter, nearly fifty residents were observed in the dining room waiting for dinner. At 5:00 PM on , all the residents sat in the dining room with only one server serving them water and juice. The server, Staff G, carried the cups holding two in one and two in the other. Staff G held the cups with her gloved touching the drinks inside the cups. At about 5:30 PM, when the server started bringing out the meals, she brought them out from the kitchen one plate at a time. Staff G did not change her gloves as she carried meals from one resident to another and entering and exiting the kitchen on multiple occasions and touching her hair and body from time to time. On at 12:00 PM, the same occurrence was present, residents lined up to enter the dining room and insufficient dietary staff to assist with the meals. One resident who got tired of waiting for his meal left the dining room and was observed in the hallway walking to his room. In a brief interview that followed, the Resident stated, he left the dining room because "There was no food". The Administrator present during the interview asked the Resident to explain what he meant. The Resident then said, it took too long to be served, but he might consider going to the dining room later. At 12:32 PM, on , in the second dining room while observing the dining service with the Director of Operations, four residents observed sitting at a table complained they did not receive appropriate utensils (knives) to eat their meat.	A 030		

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A 030	Continued From page 7	A 030		

They said they could not cut the chicken served with their fork. Another resident showed a piece of grilled cheese served to her which was or overcooked. The Director of Operations said during the observation and interview, they had utensils for all the residents. She also stated that the staff knew to request more utensils when they lack. However, some of the residents in the dining room were observed using plastic knives to eat.

A follow-up interview with Staff C at 12:40 PM, on confirmed the facility did not in fact have enough utensils or knives for all the residents. Staff C said when they asked management for more utensils, they told them they would order more. But, it has been more than a week, they did not supply sufficient utensils.

On during diner at 5:00 PM, Resident #9 was observed using her fork with great difficulty, to cut into pieces, the meat she was werved.. Resident #9 could not use her right , but appeared to be lefthanded. No one assisted Resident #9 to cut the meat. The issue was immediately brought up the Administrattor's attention. Thereafter, the Administrator made an attempt to assist Resident #9, however, Resident #9 refused because she was almost done.

At 11:52 on , Staff G said she has been working at the facility for a year. It has been difficult for her to do her job because most of the time she is the only one serving nearly fifty residents. Staff G said other staff assist only when it gets very hectic.Staff G said the Residents often get frustrated, curse and or leave the dining room without eating.

During the exit meeting with the Administrator, the

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A 030	Continued From page 8 Regional Director of Operations (RDO), and the Assistant Administrator, on at 3:00 PM, the findings were discussed. The Administrator and the RDO said they will address all the identified concerns. Class III	A 030		
A 052	429.256( ): 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his	A 052		

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A 052	Continued From page 9 or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , ,. converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of	A 052		

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A 052	Continued From page 10 administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the	A 052		

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A 052	Continued From page 11 resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on interview and records review, the facility failed to ensure that 1 of 9 sampled residents (Resident #6) received medications prescribed by her physician in a timely manner.	A 052		

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A 052	Continued From page 12 The findings included: On at 3:00 PM, Resident #6 stated she did not receive her medications, as her physician prescribed. Resident #6 was asked to provide the list of medications she was supposed to receive and she handed the list to the Surveyor. When asked which medication she did not receive, Resident #6 said she did not receive her , . Acompanied by Staff H, the Medical Technician who assisted Resident #6 take her medications, reconciliation of the list of medications on the record provided by the resident and that kept by the facility in the electronic medication observation record (eMOR) was completed and they matched, except for the , . Review of the physician orders revealed the medication , was discontinued by the resident's physician on and replaced with another medication. However, during verification of the medications marked as administered in the eMOR with those maintained in the medication cart, two medications were noted missing. The missing medications were: a) ER 9 mg tablet. (Take 1 capsule by once daily, effective for Chron's); b) , 50 mg capsule (take 1 capsule by twice daily on an empty for Generalized , effective); On at 10:00 AM, Resident #6 stated she didn't receive all her medications. She added that she went to the hospital yesterday ( ), they gave her . She said they	A 052		

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A 052	Continued From page 13 only gave her one dose. Resident #6 stated she had since she returned to the facility. She said " I am going to die if I do not receive my , medication" (which was discontinued by her physician). Resident #6 exhibited a very high level of . Review of the eMOR revealed it was signed daily as to indicate that Resident #6 had received all her medications, including the missing ones. However, the two medications above were not available and were never delivered to the facility. On at 12:19 PM, the Administrator stated since Resident #6 came from the hospital to the facility on , the medications , and Burosemide were not ordered. She explained that the hospital had sent the orders directly to the pharmacy. When they contacted the pharmacy on , after discovering this problem, they were told that an email was sent to the facility requesting a signature from the Resident's physician in order to dispense the medications to the facility. The Administrator said when they checked their emails, they didn't see the request from the pharmacy. Consequently, the medications were not ordered. Subsequently, the Administrator was asked, who was supposed to reconcile the medications with the eMOR? The Administrator said the facility's nurse was supposed to review the medications daily to ensure all medications were accounted for. However, this was not completed. Review of the health assessment (AHCA form 1823) dated documented Resident #6 was diagnosed with , , , Crohn's . Resident #6's hospital	A 052		

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A 052	Continued From page 14 records further documented her diagnosis of Generalized (GAD). The 1823 also revealed Resident #6 required assistance with self-administration of medications. During the exit meeting on at 1:30 PM. the findings were discussed with the Administrator, the Regional Director of Operations, and the Assistant Administrator. They expressed understanding of the gravity of the situation and eagerly sought to rectify the situation. Class III	A 052		
A 054	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number;	A 054		

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A 054	Continued From page 15 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on records review and interview, the facility failed to ensure the electronic medication observation record (eMOR) were accurate and documented any omission or missed dosages of medications while assisting 1 of 9 sampled residents (Resident #6) with self-administration of her medications. The findings included: On at 3:00 PM, Resident #6 said she did not receive her medications as her physician prescribed. Resident #6 provided the list of medications prescribed to her upon Surveyor's request. Resident #6 was noted to be overly about her missing medications. Reconciliation of the medications list and the electronic medication observation record (e-MOR), with Staff H, a Medical Technician who reported that she assisted Resident #6 take her medications, matched except for one medication that was not listed in the eMOR. Upon further review of the e-MOR, it was noted that all medications were marked as administered. Yet, when the medications in the medication cart were reviewed, two of the medications in the list were missing.	A 054		

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A 054	Continued From page 16 The missing medications were: a) ER 9 mg tablet. (Take 1 capsule by once daily, effective for Chron's); b) 50 mg capsule (take 1 capsule by twice daily on an empty for Generalized effective); Review of the eMOR revealed it was signed daily indicating that Resident #6 received the missing medications. However, the two medications above were not available and were never delivered to the facility. Therefore, the resident never received the medications. Staff H stated on at 12:08 PM, that it was a mistake, she did not mean to put a check on the medications she did not give. Staff H stated that it was a glitch in the computer system due to slow internet signal. When asked if she had reported that the medications were missing to anyone else, Staff H said she gave report to other Medical Technicians when she worked. She said the medications were missing for about two weeks. On at 12:19 PM, the Administrator stated since Resident #6 came from the hospital to the facility, on , the medications and Burosemide were not available. She explained that the hospital had sent the orders directly to the pharmacy. When they contacted the pharmacy after this issue was discovered, they were told that an email was sent to the facility requesting a signature from the Resident's physician in order to dispense the medications to the facility. The Administrator said when they checked their emails, they did not see	A 054		

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A 054	Continued From page 17 the request from the pharmacy. Consequently, the medications were not ordered. When the Administrator was asked, who was supposed to reconcile the medications with the eMOR, the Administrator said the facility's nurse was supposed to review the medications daily to ensure all medications were accounted for. Review of the health assessment (AHCA form 1823) dated documented Resident #6 was diagnosed of , , , Crohn's . Resident #6's hospital records further documented the diagnosis of Generalized , (GAD). The 1823 also revealed Resident #6 required assistance with self-administration of medications. During the exit meeting on at 1:30 PM. the findings were discussed with the Administrator, the Regional Director of Operations, and the Assistant Administrator. They expressed understanding of the gravity of the situation and said they will address it. Class III	A 054		
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.	A 152		

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A 152	Continued From page 18 (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 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, and interview, the facility's door security system was not functioning properly in 3 of 5 exit doors (Northside exit door, West exit door; & Southwest exit door) to prevent elopement and residents' safety. The facility also failed to maintain an environment that was safe and free of debris (cigarettes butts) in the interior courtyard. The findings included:	A 152		

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A 152	Continued From page 19 During a tour of the facility on at about 1:16 PM with the Administrator, it was noted that there were five exit doors that led to outer court of the facility and to the street. The Administrator informed the Surveyor during the tour that all the doors were alarmed and required a number code for the alarm to be deactivated. The Administrator also said that a staff member sits at the front desk of the facility to grant residents, visitors access in and out of the facility. However, the exit door leading to the Northside of the facility opened once the push bar was pressed upon. The alarm was not activated. The Administrator claimed that a staff member might have left the door unlocked. Next, we pressed upon the Westside exit door push bar and the door opened without the 15-second delay, but the alarm was faintly activated. The alarm was not loud enough. Then, we observed the South Exit door did not operate properly. It opened once the push bar was pushed. A resident count was immediately initiated. Except for residents that were marked as away from the facility, all the other residents were accounted for. On , at about 4:00 PM, it was observed there were cigarettes butts dumped all over the courtyard. They were mostly evident at almost every exit point leading to the courtyard (e.g. the Westside, the Northwest Corner and the Northeast corner) (Photographic evidence obtained). There were residents sitting down under the porch near the activity room smoking although a sign visibly noted "no smoking zone". At 4:20 PM, on , the Administrator	A 152		

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A 152	Continued From page 20 said, she had asked the residents not to dispose of cigarettes butts on the ground, but they continue to do it. She said she simply asked housekeeping to clean them up. On , at about 10:30 AM, the same situation was evident, the cigarettes butts were still on the ground, and residents were observed near the exit doors smoking. At 1:00 PM on , the Administrator and the Regional Director of operations were again informed of the cigarettes butts that were still on the ground. They said they will have the areas cleaned up and they will address the issue with the residents. At 3:00 PM on , Residents #7 and Resident #8 complained that cigarette smoke/vapor often enter the hallways and make the environment unpleasant for people who do not smoke. They said they brought those issues to the Administration many times, but nothing is done. On at 10:00 AM, the surveyor observed cigarettes butts below the air conditioning wall unit near the Southwest exit corner of the facility and a cigarette lighter on the floor. Four residents were observed smoking near the exit doors where there no smoking signs. The findings were discussed with the Administrator and the RDO at the exit meeting. No additional information was provided. Class III	A 152		

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A 165	Continued From page 21	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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A 165	Continued From page 22	A 165		

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 23 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 records review and interviews, the facility failed to report and submit 1 of 3 adverse incident reports in a timely manner. The findings included: Review of the facility's incident reports revealed the following incident was recorded and submitted eight days late to the the regulatory agency: The facility reported on that Resident # 3, a , male had an altercation with a former resident, Resident # 10, on at 7:25 PM. It was outlined that during their argument, Resident #3 had pushed Resident #10 to the floor with his scooter. The incident was reported to the police. Resident #10 pressed charges against Resident #3 and Resident #3 was then . It was further noted that the argument started in the front lobby of the facility. There was no indication of any staff intervention prior to the escalation of the situation. Although the incident occurred on , the facility did not report it until . Further record review	A 165		

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A 165	Continued From page 24 revealed Resident #3 did not return to the facility. During an interview with the Administrator and the Regional Director of Operations on at 11:04 AM, they stated they did not know that this adverse incident was supposed to be reported within one day to the agency for healthcare administration. Class III	A 165		