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 _____	01/22/2026

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
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 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	ZZ875		

AHCA Form 3020-0001

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

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ZZ875	Continued From page 1	ZZ875		

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 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,

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ZZ875	Continued From page 2 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 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.	ZZ875		

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ZZ875	Continued From page 3 (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 Center failed to ensure that staff completed the required 1-hour video training for 2 of 5 staff reviewed (Staff A and B). The findings include: A review of Staff A (Administrator) facility file and documents revealed that she was hired on and interacts with/or provides direct care to residents of the facility. Review of the file did not reveal documentation that she had taken the 1-hour video training as required for staff interacting with or providing personal care to residents.	ZZ875		

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ZZ875	Continued From page 4 A review of Staff B, Medication Assistant (MedTech) facility file and documents revealed that she was hired on /202, works the 3:00 PM - 11:00 PM shift, and provides direct care and medication assistance to residents of the facility. Review of the file did not reveal documentation that she had taken the 1-hour video training as required for staff interacting with or providing personal care to residents. In an interview with the Administrator and Regional Director on at 3:32 PM, they were informed of the missing items above. They acknowledged the findings and stated they would make sure the training(s) were completed. Class III	ZZ875		

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A 000	Initial Comments An unannounced Relicensure, Complaint (2025019211, 2025014943, 2025012472, 2025009965, and 2025018665) and Generator Monitoring survey was conducted on - at Cherry Oak Palm Beach County. The facility had deficiencies related to the Relicensure, Generator Monitoring and Complaint (#2025019211, 2025014943, 2025009965, and 2025018665) at the time of the survey.	A 000		
A 010	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices.	A 010		

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A 010	Continued From page 1 (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been	A 010		

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A 010	Continued From page 2 placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services	A 010		

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A 010	Continued From page 3 license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however,	A 010		

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A 010	Continued From page 4 staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, it was determined that, the facility failed to ensure a resident was reassessed for continued residency by his/her Healthcare Provider upon signficiant health and diagnosis changes for the resident and the findings documented on a new Health Assessment (AHCA Form 1823), for 1 of 2 sampled residents (Resident# 5). The facility also failed to ensure that the resident upon reassessment was evaluated for continued residency to ensure that the facility was capable of providing all levels of care required by the resident. The findings included: During a tour of the facility at the time of the survey, this surveyor observed on at 9:42 AM that Resident #5 was lying in bed watching television. During an interview conducted on at 9:44 AM with Resident #5, he stated that staff repositioned him twice a day. He stated that staff caused while trying to pick him up. He also stated that he is bedbound and cannot do much on his own. During an interview conducted on at 9:54 AM with Staff E (Medtech), she stated that the resident moved in at the facility with a , . She stated that Resident #5 required four staff to transfer him. Further, she stated that Resident	A 010		

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A	Continued From page 5 #5 stayed in bed most of the time. She also stated that Resident #5 is too heavy and that staff had to call 911 to help them with Resident #5 transfer's. During an interview conducted on at 9:56 AM with Staff G (Medtech) , she stated that Resident #5 required four Staff members to assist him with activities daily living (ADL's). She stated that Resident #5 was admitted with beds sores. During an interview conducted on at 10:02 AM with Staff J (Medtech), she stated that Resident #5 required higher level of care. Further, she stated that Resident #5 required four to five Staff members to assist him. During an interview conducted on at 10:06 AM with Staff L (Certified Nursing Assistant), she stated that Resident #5 should not be at the facility because Staff cannot provide the appropriate care that he required. During an interview conducted on at 11: 39 AM, with Staff A (Administrator), she stated that she agreed that Resident #5 required high level of care. She further stated that Staff had mentioned to her that they cannot provide the appropriate care for Resident #5. Staff A also confirmed that Resident #5 required three Staff to assist him with ADL's, and that he has , in his . During a confidential interview conducted on at 2:00 PM, with a third-party provider, she stated that Resident #5 was not appropriate to reside at the facility, and that he is only able to feed himself, however, he is mostly dependent.	A 010		

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A 010	Continued From page 6 Review of Resident #5's Health Assessment (AHCA 1823 form) revealed that he was admitted to the facility on . Further review of Resident #5's Health Assessment (AHCA 1823 form), signed and dated by a licensed physician on , documented the followings: Medical History and Diagnoses: Dependence, , , , Care. Physical or Sensory Limitations: Ambulates via elect Activities of Daily Living: The resident requires assistance with the following: Ambulation, Bathing, , toileting and transferring. The resident is independent with : Eating and grooming (Self- care). During in interview conducted on at 4: 16 PM with the Administrator, he acknowledged the findings. Class III	A 010		
A 031	59A-36.007(6) FAC Resident Care - Third Party Services (6) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, , and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided	A 031		

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A 031	Continued From page 7 the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the , resident's needs. (c) The administrator or designee must ensure that: 1. Care coordination includes documented communications about the resident's condition and response to treatment or services ordered by the physician which may impact the resident's appropriateness for continued residency in the facility; 2. Communications occur at least once every 30 days and whenever there is a significant change in the resident's condition; and 3. If physician ordered treatments or services occur less often than once a month, communications must be conducted according to the ordered treatment or service schedule and whenever there is a significant change in the resident's condition. 4. When communication with the third party provider is unsuccessful, at least two attempts at communication on two separate days must be documented. Documentation must include the	A 031		

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A 031	Continued From page 8 name of the person from the third party provider with whom contact was attempted, the method of communication, and the date and time of the attempts. This documentation must be included in the resident's record in accordance with the timeframes in subparagraphs 59A-36.007(6)(c)2. and 3. (d) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to document communication between the facility and Third Party services. The facility failed to keep documented communication and/or services by the physician's ordered treatment and/or service schedule for 2 of 2 sampled residents (Resident #30 and #9). The findings included: During an interview on at approximately 10:30 AM, the Administrator was asked to provide a list of residents receiving third party services. At this time, she confirmed the facility has residents on hospice services and medication administration (home health services). 1.) During a medication pass on at approximately 8:00 AM Staff G (Medication Technician) stated Resident #30 receives	A 031		

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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 031	Continued From page 9 injections by third party services. At this time, she was informed to provide a copy of the Medication Observation Record (MOR) and third-party services documentation that the resident is receiving . Further into the interview she stated she was not aware of where the facility keeps documentation related to medication management ( ). Record review of the MOR for Resident #30 dated documented as follows: a) 100 unit/ML vial, inject 20 units twice daily. b) 100IU/ML 10ML vial, 301-350=10 units, 351-400 15 units greater than 400 notify Medical Doctor (MD). c) 100IU/ML 10ML vial, AccuChek twice daily with coverage 151-200= 3 units 201-250= 5 units, 251-300 8units During an interview on at approximately 9:30 AM, the Administrator was informed to provide the file for Resident #30 containing third party services documentation on daily readings for medication administration on: 100IU/ML 10ML vial, AccuChek, twice daily, with coverage 151-200= 3 units 201-250= 5 units, 251-300 8units. The Administrator confirmed the facility had no information available for review at this time. However, she was going to call the nurse from third party services (home health) so she could provide the requested documentation. At the time of the surveyor's intervention, the facility requested the file from the third party services for Resident #30.	A 031		

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A 031	Continued From page 10 2.) During a medication pass on at approximately 9:30 AM Staff B (Medication Technician) confirmed Resident #9 was receiving third party services (hospice). Staff B was informed to provide a copy of the MOR. Further review of the MOR revealed the following medications: - 0.5mg/2ml, refused by the resident every day from through 20 for the 8:00 AM and 8:00 PM dose. - 180mg, refused by the resident on , 8, 9, 11,15,17,18,19 and 20 for the 8:00 AM dose. - , 10mg, refused by the resident on , 8,11,15,17,18,19 and 20 for the 8:00 AM dose. - 50mcg, refused by the resident every day from through 20. - , one carton (237ml), refused by the resident on ,13, 15, 17, 18, 19 and 20 for the 8:00 AM dose. And refused for the 5:00 PM dose on , 11, 12,13, 14,15, 17 and 18. - , 20mg, refused by the resident on , 8, 11,15,17,18,19 and 20 for the 8:00 AM dose. - 10mg, refused by the resident on , 8, 11, 15,17,18,19 and 20 for the 8:00 AM dose. - 10mg, refused by the resident on ,9,10,11,12,13,14, 15,17,18 and 19 for the 8:00 PM dose. - ,000 IU/ML, refused dose on through at 12:00 AM, / refused dose on through at 6:00 AM, / refused dose on through at 12:00 PM, / refused dose on through at 6:00 PM. - 20mg, refused dose by the resident	A 031		

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A 031	Continued From page 11 on , ,7,8,9,11, 15,16,17,18 and 19 at 7:00 AM. - , 100mg, refused dose on , ,2,3,4,6,7,8,9,10,11,12,13,15,17,18,19 and 20 at 12:00 AM. / refused dose on , ,8,9,11,14,15,16,17,18,19 and 20 at 6:00 AM. / refused dose on , . ,12,14,15,17,18 and 19 at 12:00 PM. / refused dose on , ,8,9,10,11,12,13,14,15,16,17,18 and 19 at 6:00 PM. - 50mg, refused dose by the resident on , through the19 at 8:00 PM. - Voltaren Arth 1% Gel, refused dose on , through the 20 at 8:00 AM. / refused dose on , through the 19 at 5:00 PM. - 20mg, refused dose on , , 8, 11, 15, 17,18,19 and 20 at 8:00 AM. During an interview on at approximately 10:45 AM with Staff B (Medication Technician), she was informed to provide communication documented from third party services (hospice) in regards to resident's medication refusal. At this time, she stated she was not aware of what is documented from hospice. During an interview on at approximately 2:15 PM, the Administrator was asked to provide communication documented from third party services (hospice) where the healthcare provider notified the facility (plan of care) in regards resident's care due to medication refusal. During an interview on at approximately 9:00 AM, a second request was made to the Administrator to provide communication documented from hospice for Resident #9. At this time, she stated the facility	A 031		

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A 031	Continued From page 12 does not have information available for review. However, she was going to call the nurse from hospice so she could provide the requested documentation. At the time of the surveyor's intervention, the facility requested most recent plan of care from third party services for Resident #9. During an interview on at approximately 4:45 PM, the team of surveyors met with the Administrator and the Regional Director. This surveyor informed them of the findings mentioned above. The Administrator was reminded that the facility is required to maintain documented communication from third party services. Class III	A 031		
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 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	A 032		

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A 032	Continued From page 13 415.1051, 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 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	A 032		

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A 032	Continued From page 14 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, it was determined that, the facility failed to ensure that staff participated in elopement drills during the year 2025 for 1 of 3 staff sampled (Staff C). The findings included: Record review revealed that Staff C , hired on as a Certified Nursing Assistant (CNA), did not participate in any elopement drills in 2025 as required. During an interview conducted on at 4:40 PM with the Administrator, she stated she thought Staff C had participated in elopement drills because Staff C had been employed since 2024. The Administrator acknowledged the findings. Class III	A 032		
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	A 052		

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A 052	Continued From page 15 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 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	A 052		

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A 052	Continued From page 16 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 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.	A 052		

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A 052	Continued From page 17 and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to 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	A 052		

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A 052	Continued From page 18 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 observation, record review and interview, it was determined that, the facility failed to ensure that unlicensed staff, Medication Technician (Med Tech) followed appropriate procedures when assisting with self-administration of medication. It was determined that Staff(Med-Tech) failed to orally announce the name and dosage of the medications at the time of medication pass, for 3 of 6 sampled residents (Residents #28, #29 and #30). The findings included: An observation during medication passes on at approximately 7:50 AM, Staff G (Medication Technician) assisted with self-administration of medication to the following residents: 1) Resident #28 a) . 10 MG, 8:00 AM b) . 100 MG, 8:00 AM c) . 0.5 MG, 8:00 AM	A 052		

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A 052	Continued From page 19 d) 100 MG, 8:00 AM e) 40 MCG, 8:00 AM f) 300 MG, 8:00 AM g) 50 MG, 8:00 AM h) 800 MG, 8:00 AM i) 10 MG, 8:00 AM j) 40 MG, 8:00 AM k) 10 MEQ, 8:00 AM This surveyor observed, Staff G did not orally advise Resident #28 of the name and dosage of the medications mentioned above. 2) Resident #29 a) 3 MG, 8:00 AM b) 600 MG, 8:00 AM c) 25 MG, 8:00 AM d) 500 MG, 8:00 AM e) 50 MCG, 8:00 AM f) 50 MG, 8:00 AM g) 10 MG, 8:00 AM h) 2 MG, 8:00 AM This surveyor observed, Staff G did not orally advise Resident #29 of the name and dosage of the medications mentioned above. 3) Resident #30 a) 250 MG, 8:00 AM b) 100 MG, 8:00 AM c) 25 MG, 8:00 AM d) 2 MG, 8:00 AM This surveyor observed, Staff G did not orally advise Resident #30 of the name and dosage of the medications mentioned above. During an interview on at approximately 9:00 AM with Staff G, she was asked if Residents #28, #29 and #30 had a	A 052		

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A 052	Continued From page 20 written waiver to opt out of being orally advised of the medication name and dosage and she stated she was not aware. During an interview on at approximately 2:50 PM, the Administrator confirmed Residents #28, #29 and #30 do not have a written waiver to opt out of being orally advised of the medication name and dosage. No additional information was provided. Class III	A 052		
A 056	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the	A 056		

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A 056	Continued From page 21 circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be	A 056		

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A 056	Continued From page 22 kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, it was determined that, the facility failed to ensure that Staff assisting residents with self-administered medications, followed the physician orders as shown on the medication label, 3 of 6 sample residents (Resident #12, #14 and #28). The findings included: A Medication Observation Record (MOR) must include the name of the resident, the name of each medication prescribed, the strength and direction of use. 1) An observation on at approximately 12:00 PM, during medication pass, Staff B	A 056		

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A 056	Continued From page 23 (Medication Technician) was observed assisting Resident #12 with self-administration with her medication for , 25mg tablet. Further review of the medication label on the medication revealed the following parameters and directions: , 25mg tablet, take one tablet by three times daily with food, 8:00 AM, 12:00 PM and 5:00 PM. During an interview on at 12:11 PM, surveyor asked Resident #12 if she had lunch. At this time, the resident stated "no". During an interview on at approximately 12:20 PM Staff B was asked why she was not following medication parameters (direction of use) Staff stated she was not aware of the direction of use at the time of medication pass. 2) A Medication Audit was conducted on between 1:00 PM and 4:00 PM the Administrator was informed to provide Resident #14 and 28 Medication Observation Record (MOR). a) Record review of Resident #14's MOR dated , documented as follows: , 125 MCG, take one tablet by once daily for , , (Hold for rated less than 60). During an interview on at approximately 1:35 PM, the Administrator was asked to provide documentation and/or log(s) for Resident #14 documenting his vital signs (rate). At this time, the Administrator confirmed the facility does not have documentation to show resident vital sings (rate) before medication	A 056		

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A 056	Continued From page 24 was given. b) Record review of Resident #28's MOR dated , documented as follows: 2% Cream (60 GM), apply cream , to affected skin on , for two weeks or until improves mix with 2.5% for the week on. However, further review of the MOR revealed medication was offered everyday consecutively from through (signed every day by the medication technician on duty). No additional information was documented on the MOR to reflect the status of the . 0.1%, apply cream , to irritated skin on both twice daily, one week on, then one week off. Further review of the MOR revealed medication was offered everyday consecutively from through (signed every day by the medication technician on duty). During an interview on at approximately 1:45 PM, the Administrator was informed of the findings mentioned above. She acknowledged the findings. No additional information was provided. During an interview on at approximately 2:00 PM, surveyor met with the Administrator, and she was informed of the concerns regarding unlicensed personnel (Medication Technician) not following medication direction of use at the time of medication pass. Class III	A 056		

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A 079	Continued From page 25	A 079		
A 079	59A-36.010(3) FAC Staffing Standards - Levels	A 079		

(3) STAFFING STANDARDS.
(a) Minimum staffing:
1. Facilities must maintain the following minimum staff hours per week:

Number of Residents, Day Care Participants, and Respite Care Residents	Staff Hours/Week
0-5	168
	212
16-25	253
26-35	294
36-45	335
46-55	375
56-65	416
66-75	457
76-85	498
86-95	539

For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week.
2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours.
3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility.
4. In facilities with 17 or more residents, there

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A 079	Continued From page 26 must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in	A 079		

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A 079	Continued From page 27 meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the	A 079		

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A 079	Continued From page 28 minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review, interview and observation, the facility failed to establish/or maintain staffing levels required to ensure that an adequate number of staff were available to assist in providing Activities of Daily Living (ADL) to residents in a timely manner. The facility had a Resident Census of 80 at the time of the survey. The findings include: A review of the facility's Resident Agreement revealed the Resident Bill of Rights as part of	A 079		

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A 079	Continued From page 29	A 079		

their Resident packet. A review of the Bill of Rights documented the following: 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 (Statute), which are consistent with established and recognized standards within the community (copy obtained).

A review of the facility's census sheet revealed a census of 80 residents. It was noted a majority of the residents require supervision and/or assistance with ADL. During confidential residents' interviews, it was revealed signficiant concerns regarding inadequate staffing to meet the care needs of the residents.

In an interview with Resident #16 on at 11:06 AM, she stated the food is terrible, there are 2 residents here (at the facility) that steals, and that there is no one available to assist residents after 11:00 PM. Thus, the resident stated there is no one available to perform health care services during the shift.

In an interview with Resident #20 on at 11:22 AM she stated she the food is terrible, some of the staff is rude (no names given), they won't help her with showers, so she washed herself/ sometimes. She stated they have call buttons in the room, but they don't work.

In an interview with Resident #21 on at 11:25 AM, he stated the food is not so good, and that he can do things himself. However, the

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A 079	Continued From page 30 Resident was observed sitting in a wheelchair with dirty clothes, un-showered with a smell, and an unkept hygiene look. In an interview with Resident #26 on at 12:42 PM, he stated he is okay, food okay, and the staff okay. He stated the call bell system in his room doesn't work, and that he doesn't know how to get hold of staff, except at the nurse's station. Observation of the Resident during the interview revealed he was sitting in a wheelchair outside his room in dirty/soiled clothing and appeared to be unkept, un-showered with a foul body smell. Prior to the interview, this surveyor observed the Resident for several minutes in the middle of the West section's hallway twitching in his wheelchair and gnashing his . No Staff member assisted him. In an interview with Resident #27, he stated to this surveyor that the food is getting better. During the interview observation by this surveyor was made of the call light outside his room that was on. This surveyor asked how he gets hold of staff if he needs something. He stated he walks to the Nurse's station or yells until someone comes. In an interview with Resident #31 on at 11:22 AM, he stated he is doing okay and sees staff sometimes, when they give his medications. This surveyor asked what he does when he needs assistance and he stated he has to go to the nurse's station if he needs assistance. The Resident's room is located near the Northwest section of the facility, and the Nurses Station is located in the middle of the South section of the facility, approximately 150 - 200 away from his room (copy of floor plan obtained). Observation during the interview revealed the Resident is a double , ( ) and was	A 079		

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A 079	Continued From page 31 sitting I manual wheelchair as he stated his electric scooter has been for months. In an interview with Resident #32 on at 11:49 AM she was doing okay and getting her medications. She stated the call-bell in her room isn't working, so you can't get anybody if you need someone. And that residents have to call 911 themselves. A review of the facility's Staffing Schedules for , and documented and a daily average of Direct care staff (MedTech and Certified Nursing Assistants) available daily during the 7:00 AM - 3:00 PM shift. During the 3:00 PM - 11:00 PM shift, there are 4 direct care staff (MedTech and Certified Nursing Assistants) documented as available in the facility. It also documents there are two (2) direct care staff (Certified Nursing Assistants) to assist residents with ADLs (copies obtained). Observation by this surveyor during the survey revealed the facility may ask/request staff to work different/multiple shifts, or assist in different capacities, as evidenced during the survey on with Staff B who was said to work the 7:00 AM - 3:00 PM. However, a review of the facility's Staffing Schedule for , and documented her as working the 3:00 PM - 11:00 PM shift (copies obtained). Observation of Staff M, Activity Director, was observed by this surveyor on , and interacting with residents in her capacity as recreation coordinator, and assisting in the kitchen with prep work, plating and serving of the lunch meals.	A 079		

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A 079	Continued From page 32 Observation during the survey (-) revealed staff J (who was hired on as a Caregiver), performing multiple assignments (Receptionist, Server, Caregiver and assisting with Laundry) during the survey. As such, she was unable to perform her primary duties as a caregiver for which she was hired. During the Exit Conference with the survey team, Administrator and Regional Director on beginning at 4:12 PM this surveyor explained that repurposing staff as needed (i.e. Staff J functioning as Receptionist, Server, Caregiver and assisting with Laundry); and/or staff working multiple shifts, etc. is a prerogative facility. However, it takes away from the time they are/or should be available to assist residents, as indicated during the survey. They both acknowledged the findings. Class III	A 079		
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	A 081		

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A 081	Continued From page 33 employee ' s personnel record. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 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.	A 081		

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A 081	Continued From page 34 (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement. (b) Staff who provide direct care to residents 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 ,	A 081		

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A 081	Continued From page 35 neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an 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 that staff had completed/or had documentation of completing all the required Inservice Trainings for 1of 5 staff reviewed (Staff B).	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 36 The findings include: A review of Staff B, Medication Assistant (MedTech) facility file and documents revealed that she was hired on /202, works the 3:00 PM - 11:00 PM shift, and provides direct care and medication assistance to residents of the facility. However, the review did not contain documentation that she had received/completed training for Resident Rights, Reporting Major Incidents, Elopement and Nutritional & Safe Food Handling. In an interview with the Administrator on at 11:29 AM, she was informed of the record review findings for Staff B and provide with an opportunity to review the file. She stated she would review the files to see if they are the Staff member had taken the trainings. They had not been completed prior to the review. Class III	A 081		
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	A 083		

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A 083	Continued From page 37 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 that 4 of 5 staff members reviewed had valid/current First Aid certification in the files or available for review (Administrator, Staff A, C and K). And to ensure that a staff member holding valid/current First Aid certification was present in the facility at all times. The findings include: A review of Staff A, Administrator facility file and documents revealed that she was hired on and interacts with/or provides direct care to residents of the facility. The review also revealed a Basic Life Support (BLS) certificate with a certification period of - . However, there was no documentation for First Aid in the file. A review of Staff K, Medication Assistant (MedTech) facility file and documents revealed that she was hired on , works the 7:00 AM - 3:00 PM shift and provides direct care and medication assistance to residents of the facility. The review also revealed a Basic Life Support (BLS) certificate with a certification period of - . However, there was no documentation for First Aid in the file.	A 083		

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A 083	Continued From page 38 A review of Staff B, Medication Assistant (MedTech) facility file and documents revealed that she was hired on /202, works the 3:00 PM - 11:00 PM shift, and provides direct care and medication assistance to residents of the facility. The review also revealed a Basic Life Support (BLS) certificate with a certification period of - . However, there was no documentation for First Aid in the file. A review of Staff D, Certified Nursing Assistant facility file and documents revealed that she was hired on , works the 11:00 PM - 7:00 AM shift, and provides direct care to residents of the facility. The review also revealed a Basic Life Support (BLS) certificate with a certification period of - . However, there was no documentation for First Aid in the file. In an interview with the Administrator on at 11:29 AM, she was informed of the findings for Staff herself, Staff B, D and K. She was provided with an opportunity to review the files, and stated she would review the files to see if they were available at the facility, which they were not. No additional information was provided during the review. Class III	A 083		
A 090	59A-36.011(11) FAC Training - (11) TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one	A 090		

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A 090	Continued From page 39 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 that staff had completed/or had documentation of completing training for 1 of 5 staff reviewed (Staff B). The findings include: A review of Staff B, Medication Assistant (MedTech) facility file and documents revealed that she was hired on /202, works the 3:00 PM - 11:00 PM shift, and provides direct care and medication assistance to residents of the facility. However, the review did not contain documentation that she had received/completed training for . ( ). In an interview with the Administrator on at 11:29 AM, she was informed of the record review findings for Staff B and provide with an opportunity to review the file. She stated she would review the files to see if they are the Staff member had taken the trainings. They had not been completed prior to the review. Class III	A 090		

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A 093	Continued From page 40	A 093		
A 093	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of	A 093		

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A 093	Continued From page 41 the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal.	A 093		

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A 093	Continued From page 42 Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of ˻ the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, it was determined that, the facility failed to ensure a 3-day emergency food supply of non-perishable food was not expired. The Facility failed to keep 6 months of regular and therapeutic menus in file for review at the time of the survey. The findings included: During a facility tour on between 11:35 AM and 12:00 PM, this surveyor observed expired food that was stored near the laundry	A 093		

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A 093	Continued From page 43 room area. Further observation revealed that the 3-day emergency food supply had the following expired non-perishable food items (photo evidence obtained). 1) Evaporated milk (3 cases) - expired 2) Apple Juice boxes (approximately 30 juice boxes / 2 cases) expired 3) Apple sauce (32 oz Can) expired 4) Fruit salad expired (3 cans 10oz) 5) apple juice cups (4oz cups), approximately 50 individual cups expired 6) Canned Chili con carne expired 7) Beef ravioli (approximately 4 cans - 32oz) expired During an interview on at 11:39 AM, the Administrator was informed of the expired items mentioned above. She acknowledged the findings. During an interview on at 11:50 AM, the Administrator was asked to provide the last 6 months (through) of regular and therapeutic menus. Record review of the facility's Food Menu revealed the following: Former Dietitian/Nutritionist License Expired on . Furthermore, review of the and menus documented date of . However, surveyor was unable to determine if menus were created and/or expired on . During an interview on at approximately 3:55 PM, the Administrator stated she did not have documentation to support that the last 6 months food menus (regular and	A 093		

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A 093	Continued From page 44 therapeutic) were created and/or expired on . No additional information was provided. Week 1 - - menu dated Week 2 - - menu dated Week 3 - - menu dated Week 4 - - menu dated Week 1 - - menu dated Week 2 - - menu dated Week 3 - - menu dated Week 4 - - menu dated Week 1 - - menu dated Week 2 - - menu dated Week 3 - - menu dated During an interview on at approximately 4:45 PM, the team of surveyors met with the Administrator and the Regional Director. This surveyor informed them of the findings mentioned above. No additional information was provided. Class III	A 093		
A 152	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other	A 152		

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A 152	Continued From page 45 (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 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	A 152		

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A 152	Continued From page 46 failed to ensure a safe living environment for 80 of 80 residents living at the facility during the survey. And ensure that Residents of the facility is able to easily and effectively communicate with staff in the event care services are needed. The findings include: During the survey on - this surveyor conducted tours of the facility and made observations related to the facility's living environment. The following observations relating to the facility's environment were made by this surveyor: Observation of the entry/exit door located in the Northeast section of the facility that leads out to the courtyard was observed to be ajar on at 11:27 AM. This could result in ants, pests, rodents, insects and other forms of vermin entering the facility. This surveyor used some force to close the door as it does not shut completely when it is opened, unless closed with some degree of force (photo obtained). Observation of the entry/exit door located in the middle of the West section (by the vending machine) that leads out to the courtyard was observed on at 11:27 AM to be ajar. This could result in ants, pests, rodents, insects and other forms of vermin entering the facility. This surveyor used some force to close the door as it 11:27 AM does not shut completely when it is opened, unless closed with some degree of force (photo obtained). Observation of the facility's courtyard by this surveyor on between 11:41 AM and 11:55 AM revealed the yard was littered with cigarette butts (photo obtained).	A 152		

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A 152	Continued From page 47 Relative to the call system, this surveyor made observations and conducted interviews with residents related to the call bells/pullcords in their rooms. Observation and interviews revealed the following: Observation of the hallways in the South, West and North hallways where the residents' rooms are located, revealed notification lights in the ceiling. The lights were indicative of those observed in Nursing Homes and Hospitals that illuminate when the emergency call button/or cord is pulled when the person inside is requesting assistance/help. In an interview with Resident #16 on at 11:06 AM, she stated the food is terrible, there are 2 residents here (at the facility) that steals, the call buttons do not work, and there is no one available to assist residents after 11:00 PM. In an interview with Resident #20 on at 11:22 AM, she stated the food is terrible, and some of the staff is rude (no names given). She also stated that they have call buttons in the room, but they don't work. In an interview with Resident #24 on at 12:26 PM, she stated she has been in the facility a few years, they assist her with showers/ADLs, but the call bell doesn't work. In an interview with Resident #25 on at 12:34 PM, she has been at the facility for a few weeks, the call light is not working, the toilet doesn't have a cover and runs continually, the emergency pull cord in bathroom doesn't work. Observation of the emergency and toilet by this surveyor substantiated the information provided by the resident (photos obtained).	A 152		

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A 152	Continued From page 48 During an interview with Resident 26 on at 12:42 PM, observation of the pull- inside the living area of the room by the East bed revealed it was broken, and there was a gap in the wall next to it (photo obtained). In an interview with Resident #31 on at 11:22 AM, he stated he is doing okay and getting what he needed. He stated the call-bell isn't working in his room and he has to go to the nurse's station if he needs assistance. Observation of the call-bell pull cord panel located on the South wall of the room revealed it was covered by a dresser/box that was on top of it. Thus, the resident would not be able to access it if it were operable. In an interview with Resident #32 on at 11:49 AM, she stated she is doing okay and she gets her medications. She stated the call-bell isn't working, and if you needed someone, the residents would have to call 911 themselves. Observation of the facility's kitchen by the surveyor on revealed baseboards in the pantry that appeared to be rotted as wood that has been exposed to water (photo obtained). Main Dining) approximately 12 dining tables had plastic covers that were ripped, stained and discolored. 2) dinning floor had built up of dirt and grime, unkept and tacky floors. Small Dining) approximately 6 dining tables had plastic covers that were ripped, stained and discolored. 2) approximately 8 dining chairs were unkept,	A 152		

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A 152	Continued From page 49 fabric seats had stains, discolored and food spills. 3) corner walls were filthy with scuff marks. 4) approximately 4 armchair leatherlike chairs were ripped (chuck pads were used to cover the ripped areas). 5) white bottom base of the tables had built up of dirt and grime, unkept. Emergency Food Storage) dirty and stained floors 2) cobwebs on the corner walls 3) under the food rack, approximately 8 roach-like (pest) on the corner floor 4) wall baseboard had indentations and rotten wood like. Small Activity Room Observations revealed that the residents use the room to congregate, watch television, read a book and/or rest, approximately 5 armchairs leatherlike were ripped (chuck pads were used to cover the ripped areas). Upon flipping the light switch near the bookshelf, the light bulb would flicker. Furthermore, there was a strong foul smell in the room. Main Activity room Observations revealed that the residents congregate for daily activities, watch television, and/or socialize. approximately 8 armchairs leatherlike were ripped, stained and food spilled. Class III During the Exit Conference with the survey team, Administrator and Regional Director on	A 152		

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A 152	Continued From page 50 beginning at 4:12 PM, this surveyor informed them of the findings; specifically, that the call bell system was not working. The Regional Director stated they are not working as they do not provide a call bell system and it's not in their (Resident) agreement. This surveyor explained that if a facility has an apparatus for which a resident holds to be working and available for their safety and welfare, then it must be working. She acknowledged and stated they may take them out. Class III	A 152		
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	A 200		

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A 200	Continued From page 51 for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. 1. The required temperature must be maintained in an area or areas, determined by the assisted living facility, of sufficient size to maintain residents safely at all times and that is appropriate for resident care needs and life safety requirements. For planning purposes, no less than twenty (20) net square per resident must be provided. The assisted living facility may use eighty percent (80%) of its licensed bed capacity as the number of residents to be used in the to determine the required square footage. This may include areas that are less than the entire assisted living facility if the 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	A 200		

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A 200	Continued From page 52	A 200		

temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. The plan shall include information regarding the systems and equipment that will be used by the assisted living facility and the fuel required to operate the systems and equipment.
a. An assisted living facility in an evacuation zone pursuant to Chapter 252, F, S. must maintain an alternative power source and fuel as required by this subsection at all times when the assisted living facility is occupied but is permitted to utilize a mobile generator(s) to enable portability if evacuation is necessary.
b. Assisted living facilities located on a single 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

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A 200	Continued From page 53 state of emergency. The plan must include information regarding fuel source and fuel storage. 1. Facilities must store minimum amounts of fuel onsite as follows: a. A facility with a licensed capacity of 16 beds or less must store 48 hours of fuel onsite. b. A facility with a licensed capacity of 17 or more beds must store 72 hours of fuel onsite. 2. An assisted living facility located in an area in a declared state of emergency area pursuant to Section 252.36, F.S. that may impact primary power delivery must secure ninety-six (96) hours of fuel. The assisted living facility may utilize portable fuel storage containers for the remaining 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.	A 200		

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A 200	Continued From page 54 (b) Each existing assisted living facility that undergoes any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of its systems or equipment affecting the facility's compliance with this rule shall amend its plan and submit it to the county emergency management agency for review and approval. (3) APPROVED PLANS. (a) Each assisted living facility must maintain a copy of its approved plan in a manner that makes the plan readily available at the licensee's physical address for review by a legally authorized entity. If the plan is maintained in an electronic format, assisted living facility staff must 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	A 200		

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A 200	Continued From page 55 , have implemented the plan required under this rule. (b) Each new assisted living facility shall implement the plan required under this rule prior to obtaining a license. (c) Existing assisted living facilities that undergo any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of the systems or equipment affecting the assisted living facility's compliance with this rule shall implement its amended plan concurrent with any such additions, modifications, alterations, refurbishment, renovations or reconstruction. (5) POLICIES AND PROCEDURES. (a) 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.	A 200		

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A 200	Continued From page 56 (b) Each assisted living facility shall maintain the written policies and procedures in a manner that makes them readily available at the licensee's physical address for review by a legally authorized entity. If the policies and procedures are maintained in an electronic format, assisted living facility staff must be readily available to access the policies and procedures and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce the policies and procedures, either in electronic or paper format, upon request. (c) The written policies and procedures must be readily available for inspection by each resident; each resident's legal representative, designee, 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	A 200		

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A 200	Continued From page 57 permission for electronic communication has been granted, each resident and the resident's legal representative: 1. Upon the initial submission of the plan to the county emergency management agency that the plan has been submitted for review and approval; 2. Upon final implementation of the plan by the assisted living facility. 3. Annual submissions and approvals of the plan do not require notification to residents or their legal representatives unless a significant modification as defined in Rule 59A-36.019, F.A.C., has been made to the plan. (b) Each assisted living facility must maintain a copy of each notification set forth in paragraph (a) 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 observation, record review and interview, the facility failed to submit a modification request following the removal and installation of a new generator (modification) to the local Emergency Management Division for review/approval. And failed to provide documentation identifying the areas of the facility the generator would supply power in the loss of electricity. The finding include: In an interview with the Administrator, Staff A on	A 200		

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A 200	Continued From page 58 at 9:27 AM, a request was made for the facility's Emergency Environmental Control Plan (EECP). She stated the facility had a new generator installed last year ( ) and submitted all the information to the County. She provided this surveyor with a clear plastic envelope containing the specs for the generator; a Generac 18KW (Killowatt) generator which operates on natural gas. In an interview with the Administrator on at 10:20 AM, she was informed that whenever there is a substantial change to their alternative power supply (generator), a new Emergency Environmental Control Plan (EECP) request must be submitted to the local County Emergency Management Division. She stated she didn't know that, and that she would be putting in for it. In an interview with the Administrator and Regional Director, Staff O on at 3:41 PM, the Regional Director Stated the Administrator is working on submitting the EECP request. She also stated the areas covered by the generator when in use is the same as the old generator covered. This surveyor asked what that was and she stated it was in the facility's Comprehensive Emergency Management Plan (CEMP) binder. A review of the facility's CEMP 2024 binder, Annual Fire Inspection Ready Book (manual) and Fire Safety Plan & Evacuation Procedures manual by this surveyor did not reveal information related to which areas of the facility the generator provides power. In an interview with the Regional Director on at 12:11 PM, this surveyor inquired	A 200		

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A 200	Continued From page 59 again as to what the new generator would supply power to in the event of power loss. She stated the same as the previous system (generator), which this surveyor informed her he did not know what areas that were. She then requested that this surveyor speak with the Administrator who may know the answer. On , this surveyor made observation of the generator located outside on the North side of the building, just through the facility's kitchen doors. Observation of the generator revealed it is Generac 18KW system. Observation was also made of the gas lines connected to it, and the gas meter located on the Northeast of the building that supplies its fuel. In an interview with the Administrator on at 12:23 PM, this surveyor inquired as to what areas of the facility the newly installed generator provides power to (i.e. lights, electrical outlets, kitchen, TV room) in the event the facility lost electrical power, and she stated she was not sure. This surveyor asked if he could speak with the Maintenance Director, and she stated he was new and would not know. In an interview with the Administrator and Regional Director on at 3:33 PM, this surveyor asked again for them to provide information related to the area, items or rooms the generator powers when in use. The Regional Director stated it is the same area as the previous generator, and that the information was in the CEMP binder. This surveyor informed them that the information, nor an approved EECP letter, was present in any of the binders. No additional information was provided during the survey. During the Exit Conference on at 4:48	A 200		

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A 200	Continued From page 60 PM, the Administrator and Regional Director stated they had not submitted the updated information (EECP documentation related to the new generator) to the County. As the facility installed/implemented a new generator in to provide its alternative power, it was required to submit a modification request to the Local Emergency Management Division for review, which had not been submitted as of this survey. In addition, there information identifying the areas of the facility that would be powered by the generator in the loss of electricity during the survey. Class III	A 200		