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
	AL11911395	A. BUILDING: _____ B. WING _____	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENTIAL PLAZA AT BLUE LAGOON	5617 NW 7 STREET MIAMI, FL 33126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A re-licensure and complaint investigation (2026004665) survey was conducted at Residential Plaza at Blue Lagoon on - . Deficiencies were identified at the time of the survey. Class 1 deficiencies were found at tag A0030 and A0078. A Class 1 deficiency is a deficiency that the Agency determines presents a situation in which immediate corrective action is necessary because the facility's non-compliance has caused, or is likely to cause, serious injury, harm, , or to a resident receiving care in a facility. The Class 1 non-compliance began on . The facility Administrator was notified of the Class 1 non-compliance on . The census at the start of the survey was 307 residents. The facility failed to provide timely emergency care when a resident was found unresponsive. Staff confirmed that no one immediately performed , , , which placed all residents designated as full at risk for delayed or absent life-saving interventions. A review of personnel records revealed that not all staff present had received training prior to the incident. The following is a description of the deficiencies found at the time of the visit: A0025, A0036, A0052, A0055, A0093, A00152,	A 000		

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A 000	Continued From page 1 A0160, A0165, A0182, L243, N277	A 000		
A 025 SS=H	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises,	A 025		

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A 025	Continued From page 2	A 025		

and awareness of the general health, safety, and physical and emotional well-being of the resident.
(c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.
(d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change.
(e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.
(f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services.

This Statute or Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to provide appropriate supervision and maintain awareness of the health and wellbeing of two out of forty-five sampled residents (1, 2) Resident 1 was found eight hours after she was last monitored by caregivers. Resident 2 had a while she was assisted by staff, sustained and and in the hospital.

Findings included:

1)
Interviewed on at 2:44 PM Staff B stated she briefly saw Resident 1 in her room at the beginning of her shift, at around 2:00 PM and did not see her again until she was called to open the room for the Resident's daughter around 9:55

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A 025	Continued From page 3 PM when the Resident was found unresponsive. Staff B further stated that Resident 1 was partially lying in bed with her ˛ hanging to the side and never responded to her daughter. Interviewed on at 2:05 PM Team Leader C stated that sometime around 10:00 PM he responded to an emergency call for # A and found Resident 1 lying sideways on her bed unresponsive. Staff C further stated that when he checked for vital signs Resident 1 had no , and was to the touch. Interviewed on at 3:32 PM Staff D stated she responded to an emergency call for additional staff for # A and found Staff B, Team Leader C, and the Resident's daughter with Resident 1 in the room. Staff D further stated that when she attempted to check Resident 1's vital signs the Resident was and rigid. Staff D further stated she was not able to move the Resident's arm. Interviewed on at 12:22 PM Resident #1's Daughter stated the Resident had called her and told her she was not feeling well; she last spoke with the Resident at around 6:00 PM and the Resident had not eaten dinner yet, as she would normally eat around 7:00 PM to 7:30 PM. The Resident's Daughter further stated that when she called the Resident at approximately 9:30 PM to let her know she was on the way to the facility she was unable to reach her, and when she arrived at approximately 9:45 PM and could not enter the resident's room she contacted the front desk, a staff member came to open the door and she found Resident 1 lying unresponsive. Interviewed on at 1:30 PM Staff V	A 025		

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A 025	Continued From page 4 stated residents were served dinner between 5 PM and 7 PM and a dining room attendance record was not kept, however the residents' menu choices were recorded and she did not find records for Resident 1's dinner on . Staff V stated, "I remember [Resident 1] She wasn't very sociable" When asked if the facility monitored when residents missed meals Staff V stated that it was up to the assigned caregivers to be attentive. A review of Resident 1's health assessment dated revealed diagnoses of , , high , , , , , , , type 2. Physical limitations showed frailty and elderly. status showed alert and oriented. Nursing requirement showed none. Special precautions showed none. The activities of daily living (ADL) showed independence for all ADL. The resident was able to self-administer medications. A review of Resident 1's progress notes dated showed the resident returned from the hospital with discharge papers showing diagnoses of , Covid 19, ARSD-COV2-Positive, , , elevated , and hypomagnesemia with new treatment for Covid, appeared stable without , distress. A review of Resident 1's progress notes dated showed the Resident was weak due to , symptoms and she would continue to be monitored for three more days. A review of Resident 1's progress notes dated showed she was feeling better and	A 025		

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A 025	Continued From page 5 was able to participate in ADL (Activities of daily living) Further review of Resident 1's record showed no documentation for observation or progress notes from through . Further review of Resident 1's progress notes showed " 5:31 PM- Late entry dated for 3:30 PM. The Resident remains stable and independent with her ADL. Resident prefers to stay all the time in her room but attends medical , , when needed. Staff will be attentive to resident needs and report any changes" Further review of Resident 1's progress notes showed " 4:16 PM- Late entry for 11:30 AM. The Resident continues to meet the criteria to reside at our facility. She is oriented x 3, stable, and continues independent with her ADL and manages her own medications. She uses a rolling walker for ambulation and communicates clearly her needs. She sees [PCP] for her medical needs. ALF staff will be attentive to her needs. A review of Resident 1's progress notes dated at 10:04 AM showed half bed-rails were placed in the Resident's bed. A review of Resident's progress notes dated at 11:03 PM showed, "[Staff B] called me via radio for an emergency in A. Upon arrival at the unit, the CNA and the Resident's daughter were present in the room. The Resident was lying in bed with her hanging off the side. I proceeded to check for a , , and the resident did not respond to verbal or physical stimulation. I reviewed the (Do	A 025		

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A 025	Continued From page 6	A 025		

Not)status and the Resident was not listed as . The Resident was placed on the floor and was initiated immediately. 911 was called and I followed the dispatcher's instructions while continuing . The CNA brought the defibrillator to the room, and I followed the instructions provided to operate the device. Approximately 15 minutes later, rescue personnel arrived and continued providing medical care to the Resident. Rescue personnel pronounced the Resident at 10:45 PM. The Resident remained on the floor until police arrived to evaluate the case. The body was later picked up by the funeral home at 3:30 AM. An email notification was sent to the corresponding entities."

According to the Cleveland Clinic, "Frailty might be the same as in the dictionary, but it isn't the same in the medical world. The medical definition of frailty revolves around your body being able to handle more strain from illnesses or injuries.

"Frailty is when your body can't get through and recover from illnesses and injuries on its own. Your body is more with frailty, making it harder to recover from health issues. As it worsens, frailty can disable you. It can keep you from doing day-to-day tasks that are part of being self-sufficient.

'Frailty and physical are not the same. With frailty your endurance, mental health and function also play a role. Frailty happens when your body isn't healthy enough to recover from injuries or illnesses"

According to the Cleveland Clinic possible symptoms of frailty include feeling fatigued,

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A 025	Continued From page 7 trouble with balance and stability (You may more easily or more often) , , ◡ spending time in public and , . A review of the facility's General Supervision policy and procedure showed: "Purpose: To offer daily/general supervision to our residents residing in the assisted living facility to meet each resident's appropriate level of care and needs. Responsibility: All Staff Supervision: [The Facility] staff will offer personal supervision as appropriate for each resident, including the following: a- Monitoring of common areas daily for the safety of the residents b- Monitoring the quantity and quality of resident's diets c- Daily observation by designated staff of the residents' activities while on the premises and awareness of the general health, safety, and physical and emotional well-being of the residents. d- Maintaining a general awareness of the residents' whereabouts. The residents may travel independently in the community. e- General round to all residents in each shift changes by the healthcare staff. f- Contact the resident's health care provider and other appropriate parties such as the resident's family, guardian, health care surrogate or case manager if the resident exhibits a significant change. g- Maintaining a written record, updated as	A 025		

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A 025	Continued From page 8 needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services." Interviewed on at 11:38 AM the Administrator stated, "Independent residents are rounded at the end of the shift" 2) A review of Resident 2's progress notes dated 4:52 PM showed, "[Staff X] contacted me on an emergency basis to report that [Resident 2] had while being assisted to the shower. Upon my arrival, the Resident was found on the shower floor. The Resident was complaining only of severe , . Due to her mental condition, the Resident was unable to explain how the incident occurred. According to [Staff X], the part of the shower chair `became while she was attempting to transfer the Resident to the shower. She was only able to support the Resident's ; however, it is possible the Resident struck her during the . I performed a gentle assessment of the Resident's arms and . The Resident was able to move both her arms and . The shower floor was dry at the time of the incident, and the Resident was not wearing shoes. Due to the Resident's repeated complaints of , and uncertainty regarding possible injuries, I decided not to move her and contacted emergency rescue services. Immediately afterward I notified the Resident's daughter-in-law, of the incident. She agreed with the decision to call rescue services. Upon arrival, rescue personnel were the ones who lifted the Resident from the floor. The Resident continued to verbalize , , stating that	A 025		

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A 025	Continued From page 9	A 025		

her and her entire body hurt. The Resident was transported to [Hospital]. The Resident's primary care physician (PCP) was notified via phone, and a message was left. We will continue to monitor the situation and wish the Resident a prompt recovery."

A review of Resident 2's progress notes dated at 1:19 PM showed the Resident remained hospitalized and was transferred to a hospice care inpatient unit with diagnoses of and wedge or the .

A review of Resident 2's progress notes dated at 12:03 PM showed that a family member reported that Resident 1 had , the night before.

Further review of Resident 2's progress notes entry dated at 1:19 PM showed that Staff X reported that Resident 1 when the bath chair became and she did everything possible to break the Resident's and prevent a hit to the . Further review showed that the shower chair was previously used and inspected and it did not show cracks or signs of damage after it was removed and re-inspected .

A review of Resident 2's health assessment dated showed diagnoses of , , , , with Angioplasty with placement, , . Physical limitations showed the Resident needed a wheelchair with help for ambulation, food preparation, taking medications with safety, attention to all activities of daily living including personal hygiene. The status

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A 025	Continued From page 10 showed progressive (decline), limited verbal communication, and progressive memory deterioration, frequently and disoriented. Nursing requirements showed prevention, reduce risk of , and broncho . Keep adequate hydration. Avoid risk of exposure to dangerous situations. Special precautions showed prevention, , /broncho , caution, identify new medical problems. The activities of daily living (ADL) showed the Resident needed assistance with all ADL including ambulation, bathing, , eating, self-care, toileting and transferring. The Resident needed assistance with self-administration of medication and periodic medical evaluations were indicated. A review of the facility's internal Resident Incident Report showed that on at 10:55 AM Staff X reported that Resident 1 had while being assisted in the shower and was found on the shower floor complaining of severe , . Further review showed, "According to Staff X the part of the shower chair became while she was attempting to transfer the resident to the shower" A review of the facility's Assistive Device Policy showed: Purpose: To ensure the safe usage of a resident's assistive device. Responsibility: Direct or indirect care staff. Definitions: Any device designed or adapted to help a resident perform an action, a task, an activity of daily living, or a transfer; prevent a or recover from a . Various types of assistive	A 025		

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A 025	Continued From page 11 devices are: wheelchair, rolling walker, canes, commode, bath chairs, bed rails, etc. Procedures: Training: Direct care staff will receive training on assistive devices care and maintenance for each device used in the facility. This training must be completed prior to the staff providing care to the resident. The staff training will include, but it is not limited to: Checking the assistive devices for the following: e- Making sure the shower chair or bathtub chair is securely in place. 5- The facility staff must follow its procedures for recommending assistive devices repairs and/or replacement. Staff responsibilities: The Administrator or designee must explain to all staff that they must report any suspicion of assistive device potential for ◡ or if broken. Class II	A 025		
A 030 SS=K	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the	A 030		

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A 030	Continued From page 12 admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions;	A 030		

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A 030	Continued From page 13 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and	A 030		

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RESIDENTIAL PLAZA AT BLUE LAGOON	5617 NW 7 STREET MIAMI, FL 33126

(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 030	Continued From page 14 personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , ,	A 030		

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A 030	Continued From page 15 for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.	A 030		

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A 030	Continued From page 16 (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated . or . under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the	A 030		

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A 030	Continued From page 17 facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that five out of 45 residents (Residents #1, #17, #19, #20 and #21) were treated with respect, consideration, and recognition of their personal dignity. The facility failed to initiate timely life saving measures in ( ) and the utilization of an Automated External Defibrillator ( ) for Resident #1 who was found unresponsive and wished to be , which resulted in the resident's . The facility further failed to respect the privacy for Residents #17, #19, #20 and #21. Findings include: 1). A review of Resident #1's progress notes dated revealed that Resident #1 was found unresponsive in her room by Staff B (Certified Nursing Assistant) and the resident's daughter at approximately 9:45 PM. Staff B she called in an emergency to Staff C (Home Health Aide/ Team Leader). Once Staff C arrived, the resident's , was checked and he began . 911 was called and Staff C followed their instructions. An unidentified staff member brought in the	A 030		

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A 030	Continued From page 18 and Staff C followed the instructions to operate the device. Rescue arrived approximately 15 minutes later; they continued to provide care to Resident #1 until she was pronounced at 10:45 PM. Further review of the resident's file did not show that the resident had a . . . . . ( ) in place. During an interview with Resident #1's daughter on at 12:22 PM, the resident was last heard around 6 PM when she contacted her to advise her that she was not feeling well. During an interview on at 2:58 PM with Staff B, she was asked to recall what took place the night that she found Resident #1 was found unresponsive. Staff B stated that she opened Resident #1's room with a key because there was no answer; she was in attendance with the resident's daughter. When she discovered that the resident was unresponsive, she called the team leader, identified as [Staff C]. Staff B confirmed that she was trained; when asked why she did not immediately start , she stated because she "froze". She further stated that she had stepped out of the room, leaving Resident #1 and her daughter alone, because she heard something on the radio that she could not understand. She stated that she stepped out because the team leader had not arrived yet, so she thought it could have been him. She stated that she thought she followed procedures when she called the team leader after the discovery. Staff B stated that she thought she did what she was supposed to do and if she had to do it now, she would not have waited for the team leader and would have started . She later confirmed that the last time she saw the resident was around :30PM and she never went to the resident's room for about eight hours. She stated	A 030		

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A 030	Continued From page 19 that she would check on the independent residents, only at the beginning and end of her shift; she furthered that she normally does not do rounds for the independent residents. During an interview on at 2:07 PM with Staff C, he was asked to recall the night that Resident #1 was found unresponsive. He stated that he received an emergency call from [Staff B] and he arrived at the room around 10:00 PM. When asked what Staff B was doing once, he arrived, he stated that she was waiting for him, but he did not know why. He confirmed that he was the one who called rescue once he arrived. He confirmed that he only did , and they did not have a barrier for rescue breaths. According to the American Association, "For healthcare providers and those trained: conventional using , and -to- breathing at a ratio of 30:2 , -to-breaths". A review of Staff C's employee record revealed that he had an active certification issued on . A review of Cleveland Clinic's database revealed that " with breaths (conventional): You use , and -to-breaths. You need certification to do this type ... Both types are effective and can be lifesaving within the first few minutes of in adults. However, with breaths is more helpful in situations where must go on for longer than a few minutes. This is because the person's needs more at that point to prevent damage to vital like the ". During an interview on at 3:32 AM	A 030		

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A 030	Continued From page 20 with Staff D (Medication-Technician), she was asked to recall the events that occurred the night Resident #1 was found unresponsive. She stated that a call for help was received between 9:50-10:00 PM. She confirmed that once she arrived, she did not see Staff C do rescue breaths. When asked who was supposed to call 911, she stated that it would be the supervisor because he should be the first one in the room. According to the American Red Cross, " ... immediately CALL or tell someone to call 911, and get the emergency equipment. Remember you need to get on the way if the person is unresponsive ...". During an interview on at 3:44 PM with Staff E (Medication-Technician), she was asked to recall the night that Resident #1 was found unresponsive. She stated that there was an emergency call on the radio with instructions to bring the . She stated she went down to the seventh floor and gave the to the team leader. She further stated that the CNA that was assigned to Resident #1's room was looking for the at the same time that she brought it. An observation on at 6:29 AM revealed that the was located directly across the hall from Resident #1's room. A review of the emergency response procedure revealed that "Upon identifying a resident who is unresponsive or not breathing: 1. Assess the resident immediately 2. Request for assistance (additional staff / Team Leader) via radio "911" 3. Initiate (if certified) immediately unless a valid is present 4. Call 911 5. Request / Retrieve 6. Follow 911 dispatch instructions. During an interview on at 9:29 AM	A 030		

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A 030	Continued From page 21 with Resident #45, he stated "At night you will die because no one attends to us here and it is very difficult". He further stated that "they [the facility] don't train the staff". A review of the resident list dated revealed that 255 of the 307 residents wished to be in the event of a medical emergency. 2). An observation on at 6:50AM revealed that Staff S (Home Health Aid) did not knock on Resident #19, #20, and #21's door before she entered. 3). An observation at 6:13 AM revealed that Staff Q left a medication observation record binder unsecured and on top of a medication cart. Further observation revealed that Resident #17's personal health information was left exposed to all individuals in the hall, as Staff Q entered a room. Class I	A 030		
A 036 SS=D	59A-36.007(10) CONTROL PROCEDURES (10) CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of (a) The facility must implement a hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or , hygiene may	A 036		

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A 036	Continued From page 22 include the use of -based rubs, , handwash, or handwashing with soap and water. (b) Standard precautions must be used when there is an , exposure to transmissible agents in , , , , nonintact skin, and mucuous during the provision of personal services. Standard precautions include: hygiene, and dependent upon the exposure, use of gloves, gown, mask, , protection, or a shield. (c) The facility must clean and reusable medical equipment and communal assistive devices that have been designed for use by multiple residents before and after each use according to the manufacturer's recommendations. This Statute or Rule is not met as evidenced by: Based on observation and record review, the facility failed to ensure that it followed facility failed to ensure that its staff implemented proper hygiene and control precautions for two of 45 sampled residents (Resident #18 and Resident #22). Findings include: 1). An observation on at 9:43AM revealed that Resident #22 was seated with her closed in the dining room waiting area. Staff I (Registered Nurse/ Team Leader) put on pair of gloves, took the resident's temperature and then checked her saturation and rate with a . Once Staff I was done with the device, he placed the , into his supply bag; he was not observed to have wiped down the device after use.	A 036		

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A 036	Continued From page 23 An observation on at 9:46AM revealed that Staff I took Resident #22's , with a , monitor. Once Staff I finished with the device, he placed the . monitor into his supply bag; he was again not observed to not have wiped down the device after use. An observation on at 9:47AM revealed that Staff I left Resident #22's side, walked to the kitchen and returned with a cup of water for the resident. Further observation revealed that Staff I had the same gloves that he initially put on. An observation on at 9:48AM revealed that Staff I removed his gloves and threw them away in a nearby trashcan; he did not wash his . Staff I then assisted Resident #22 up from her seat by holding her arm and proceeded to assist the resident to her room. An observation on at 9:52AM revealed that Staff I assisted Resident #22 to her bed, he opened the resident's fridge, poured her a glass of milk and raised the cup to the resident. An observation on at 9:54PM revealed that after Staff I attended to Resident #22, he did not wash his . A review of the control policy revealed that staff will "Change gloves and wash between residents", "Indications for employees performing hygiene are A. Before and after direct resident care", and " ... , cuffs will be cleaned after each use by the employee who has possession of the equipment".	A 036		

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A 036	Continued From page 24 A review of Staff I's employee record revealed that he had a completed training certificate in Control and Barrier Precautions dated . 2). An observation on at 7:21 AM revealed that Staff U (Medication Technician) assisted Resident #18 with self-administration of medication. Staff U initiated the medication pass without performing hygiene, including handwashing or the use of sanitizer. Staff U greeted the resident by name and informed the resident of medications that he would be taking. The medications were placed into a small white medication cup, one at a time, from their packs. Staff U handed the cup to Resident #18 and observed the resident take the medication. Staff U then signed the medication observation records and placed the book into the first slot of the medication cart. Further observation revealed that Staff U did not perform proper hygiene before, during, or after assisting the resident with assistance with self-administration of medication. A review of the Hygiene Policy and Compliance Program revealed that all employees were required to perform hygiene to reduce the transmission of microbes and germs to residents and to prevent the growth of microorganisms on the nails, , and . According to Section Procedure 1, "Indications for employees performing hygiene," subsection A, showed that hygiene must be performed before and after direct resident care. Class III	A 036		

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A 052	Continued From page 25	A 052		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his 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	A 052		

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A 052	Continued From page 26 dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of 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.	A 052		

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A 052	Continued From page 27 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the 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,	A 052		

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A 052	Continued From page 28 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assist one out of 45 sampled residents (Resident #17) who needed assistance with self-administration of medications at the time indicated by the prescribing physician. Findings Included: Observation on at 6:27 AM showed that Staff Q (Medication Technician) assisted Resident #17 with self-administration of medication.	A 052		

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A 052	Continued From page 29 A review of Resident 17's Medication Observation Records revealed that the medications were prescribed to be administered at 8:00 AM. These medications included 40 MG Tablet, 20 MG Tablet, Tablet, D3 50 MCG Soft Gel, 15 MG Tablet, 0.2%-0.5% 25 MG, Extra Strength 800 MG Tablet, 500 MG Tablet, 320 MG, 1 MG, Tablet 40 MG, and Tablet. Interviewed on at 6:27 AM Staff Q stated that she had started assisting residents with self-administration of medications at 6:00 AM. Class III	A 052		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The	A 055		

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A 055	Continued From page 30 facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate,	A 055		

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A 055	Continued From page 31 or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based observation and record review the facility failed to ensure all over the counter medications were kept in a locked cabinet, locked cart, or other locked storage receptable, room, or area always. Findings Included: Observation on at 8:56 AM showed in	A 055		

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A 055	Continued From page 32 where Resident #16 resided had a bottle of over-the-counter 10 mg unsecured. A review of Resident 16's health assessment dated had diagnosis of . Also, Resident #16 needed assistance with self-administration of medications. A review of the facility's Medication Storage policy showed that, under the procedure section, both prescribed and over-the-counter medications were required to be centrally stored in the Medication Room on the second floor and in locked medication carts if the community offered medication management assistance or administration. Class III	A 055		
AN277 SS=D	59A-36.022(2) FAC LNS - Resident Care Standards (2) RESIDENT CARE STANDARDS. (a) A resident receiving limited nursing services in a facility holding only a standard and limited nursing services license must meet the admission and continued residency criteria specified in Rule 59A-36.006, F.A.C. (b) In accordance with Rule 59A-36.010, F.A.C., the facility must employ sufficient and qualified staff to meet the needs of residents requiring limited nursing services based on the number of such residents and the type of nursing service to be provided. (c) Limited nursing services may only be provided as authorized by a health care practitioner's order, a copy of which must be maintained in the	AN277		

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AN277	Continued From page 33 resident's file. (d) Facilities licensed to provide limited nursing services must employ or contract with a nurse(s) who must be available to provide such services as needed by residents. The facility's employed or nurse must coordinate with third party nursing services providers to ensure resident care is provided in a safe and consistent manner. The facility must maintain documentation of the qualifications of nurses providing limited nursing services in the facility's personnel files. (e) The facility must ensure that nursing services are conducted and supervised in accordance with Chapter 464, F.S., and the prevailing standard of practice in the nursing community. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility that has a limited nursing services component in it's license failed to ensure that one of the Registered Nurses employed by the facility to provide limited nursing services (Staff I) had a current copy of his registered nurse license in his employee record. Findings included: Record review of Staff I [Registered Nurse] revealed that the copy of his Registred Nurse in his emplyee record had expired on . On at 5:00 PM the Administrator stated that the record review was 'fine'. Class III	AN277		
A 078 SS=K	59A-36.010(2) FAC Staffing Standards - Staff	A 078		

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A 078	Continued From page 34 (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document	A 078		

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A 078	Continued From page 35 observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility to ensure eight out of 24 sampled staff (Staff B, C, D, E, L, M, S, and T) were qualified to perform their assigned duties according to their level of education, training, preparation, and experience. Four staff (Staff B, C, D, and E) failed to initiate , , ( ) for Resident #1 when she was found unresponsive, despite the absence of a ( ), and were unable to operate the automated external defibrillator ( ). Resident #1 was pronounced .	A 078		

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A 078	Continued From page 36 Findings Included: A review of Resident 1's progress notes records dated at 11:09 PM showed Staff C (Team Leader) reported that Staff B (Caregiver) had contacted him by radio and stated that it was an emergency in A where Resident #1 resided. Staff C further stated that he checked for a , , and the resident did not respond to verbal or physical stimulation; the resident was unresponsive. Interviewed on at 2:56 PM Staff B (Caregiver) stated that she checked on the resident at the start of her shift at 2:00 PM and did not return until she received a radio call that assistance was needed in the resident's room near the end of her shift at 9:45 PM. Interviewed on at 12:22 PM Resident #1's Family Member stated that she had received a call from the resident stating that she was not feeling well. The family last spoke with the resident around 6:00 PM and noted that the resident had not yet eaten dinner, as she would normally eat around 7:00-7:30 PM. At approximately 9:30 PM the family member called the resident to inform her that she was on the way to the facility. After attempting to reach the resident by phone without success, Resident #1's Family Member arrived at the facility at approximately 9:45 PM. Upon arrival, Resident #1's Family Member was unable to access the resident's room and, after knocking without receiving a response, contacted the front desk to request assistance. Staff B arrived and provided access to the room. Upon entry, both the family member and Staff B observed Resident #1 lying in bed and unresponsive. Resident #1's Family Member stated that Staff B then called another	A 078		

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A 078	Continued From page 37 staff member for assistance rather than starting . In a continued interviewed on at 12:5 pm, Resident #1's Family Member further stated that she, along with Staff C (Team Lead), assisted the resident to the resident to the floor, while another staff member was present but did not assist, stating they had problems. Resident #1's Family Member stated the 911 operator instructed that rescue breaths be provided along with . . Resident #1's Family Member stated that no barrier mask was available, so she had to provide rescue breaths to Resident #1 while other staff were present but did not assist. Interviewed on at 2:56 PM Staff B further stated that she and the family member entered the resident's room and observed the resident lying in bed, up. Staff B reported that she called Staff C (Team Lead) over the radio; when there was no immediate response, she became panicked and stepped out of the room, leaving the unresponsive resident and the family member inside, in order to listen for further communication from the radio. At that time, the Team Lead had not responded to the call. Staff B stated that she did not perform because she "froze," despite confirming that she had been trained in . She further stated that she followed procedure by calling the team leader first. A review of Staff B's personnel records showed a hire date of and, prior to , there was no documentation confirming that she had received training in first aid or . Interviewed on at 2:06 PM Staff C	A 078		

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A 078	Continued From page 38 (Team Leader) stated that he received an emergency call from Staff B around 10:00 PM. He stated that when he arrived in the room, the family member was positioned over the resident, displaying visible emotions, and Staff B was present but not assisting. He stated, regarding Staff B, "she was just present waiting for me to arrive." The team leader stated that he asked the family member to step aside so he could begin care for the resident. He stated he verified that the resident did not have a in place, contacted 911, instructed Staff B to retrieve the Automated External Defibrillator ( ), and began performing following instructions from 911. However, Staff C also stated he requested additional assistance over the radio before starting. He stated, "I needed help with , it needs to be done as a team." He stated performed only , , as no barrier mask was available. He stated that while he continued , , Staff D (Medication Technician) applied the pads. He also stated that he was never able to deliver a using the because the device's language was set to English and he was attempting to follow instructions from the 911 operator. He also noted that the resident felt and that the family member was the one who attempted to provide rescue breaths. Interviewed on at 3:32 PM Staff D (Medication Technician) stated that she received a radio call from the Team Lead requesting assistance in the resident's room at approximately 9:50 PM to 10:00 PM. She stated that upon arrival, she got down on the floor near the resident while Staff C performed , following instructions from 911 and providing , ; she did not observe him providing rescue breaths. She also stated that	A 078		

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A 078	Continued From page 39	A 078		

she checked the resident's , upon arrival and found none. She noted that the resident was and stiff, stating, "I tried to move her , and it wouldn't move."

Interviewed on at 3:44 PM Staff E (Medication Technician) stated that she was on the 8th floor when she heard the team lead requesting assistance over the radio to the resident's room on the 7th floor. She said she took the stairs to the 7th floor and retrieved the , which was located across from the resident's room in the room labeled "Janitor." She stated that Staff B was searching for the when she arrived on the floor, noting that Staff B was new and had only been working at the facility for 15 days. After retrieving the , Staff E said she brought it into the resident's room and placed it next to the Team Lead, who was performing . while on the phone with 911. She stated Staff D was also present on the floor near the Team Lead.

A review of Resident 1's health assessment dated showed diagnoses of , , type 2 , , , , , , hyperlipoproteinemia, , , , and , . Physical or sensory limitations noted that the resident was frail and elderly.

Further review of Resident 1's records showed that there was no documentation indicating that the resident had a ( ) in her file.

Interviewed on at 6:21 AM Staff S (Home Health Aide) confirmed that she had been trained. Staff S stated, "The first thing I have

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A 078	Continued From page 40 to do is communicate to the team lead." When describing the procedure for , Staff S stated, "there is a mask for , but I don't know where the mask could be. The team leader is responsible for all of this." Interviewed on at 7:03 AM Staff M (Caregiver) stated that she was new and still was training she only worked at the facility for two weeks. Staff M was asked if she found a resident unresponsive what she was trained to do. Staff M stated, "I would notify and call the team leader by radio." Observation then revealed Staff M walking down the hall to get the radio, stated, "the radio is charging;" however, there was no radio when Staff M arrived at the place where it should have been. Staff M was asked for the location of the . Staff M stated, regarding what she thought an was, "something for fire, I don't know." Interviewed on at 7:22 AM Staff T (Home Health Aide) confirmed that she had been trained. Staff T was asked if she found a resident unresponsive what was she trained to do. Staff T stated that she would automatically call the team leader on duty. She further stated, "at this moment call the team lead, wait for instructions from the lead, and authorization from the team lead to start ." Also, Staff T stated she did not know if the procedures were a written policy, but it was a part of training that she had received when she started working at the facility four years earlier. She further stated she would use 'self-knowledge' to check the list. When asked about and the , she stated, "Oh my god, position the resident on the floor to properly start the maneuver. If the resident doesn't respond we use another item that provides some electricity; don't know the name of the item; Call 911." Staff T was then	A 078		

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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 078	Continued From page 41	A 078		

observed proceeding to the , where she successfully located the device. However, she was unable to open the device and stated that she did not know how to use it.

Further interviewed on at 7:50 AM when asked about the procedures, Staff T stated she would provide the resident with "10 and 10" , until the resident responded or until help arrived. When further asked whether she would provide breaths she responded "yes"; however, she did not specify the number of breaths.

Interviewed on at 9:29 AM regarding Staff L (Certified Nursing Assistant) stated she would call the supervisor and wait for instructions.

A review of data from the Cleveland Clinic showed, " treatment has to start right away, wherever you are. , , can happen after just five minutes without . . Survival drops sharply after 8- 10 minutes without . Starting in the first few minutes is the most important factor for survival."

A review of data from the American Association showed, "For healthcare providers and those trained: conventional using , and -to- breathing at a ratio of 30:2 , -to-breaths."

A review of Staff C's personnel records showed a hire date of and current Basic Life Support (and) training on record dated through .

A review of Staff D's personnel records showed a hire date of and current Basic Life

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	AL11911395	A. BUILDING: _____ B. WING _____	03/30/2026

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A 078	Continued From page 42 Support (and) training on record dated through . A review of Staff E's personnel records showed a hire date of and current Adult and First Aid/ / training on record dated . . . . A review of Staff L's personnel records showed a hire date of and current Basic Life Support (and) training on record dated through . A review of Staff S's personnel records showed a hire date of and current Basic Life Support (and) training on record dated through . A review of the facility's policy Residents Emergency Response Procedure No.1, showed: "Upon identifying a resident who is unresponsive or not breathing; (1) Assess the resident immediately; (2) Request for assistance (additional staff/ team leader) via radio '911'; (3) Initiate (if certified) immediately unless a valid is present; (4) Call 911; (5) Request/ Retrieve ; and (6) Follow 911 dispatch instructions." Additionally, under Use (if applicable), Bulletin 2 stated: "Staff will follow prompts during use." A review of the facility's records Incident Interview Notes showed Resident Room # [ ] dated as documented by the Administrator revealed the following summary of observations based on staff interviews and a timeline verified through available camera review: "all staff responded promptly, emergency service contacted, was deployed quickly; was performed, staff maintained composure and	A 078		

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A 078	Continued From page 43 professionalism , and overall, staff could not exercise control over the incident. The resident was unresponsive at the time the resident was found on the bed, and staff followed emergency procedures." Class I	A 078		
A 093 SS=F	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	A 093		

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A 093	Continued From page 44 by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, 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.	A 093		

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A 093	Continued From page 45 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, 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 and Interview, the facility failed to ensure that food was presented at safe temperatures for 3 of 45 sampled residents (Residents #7,11,23).	A 093		

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A 093	Continued From page 46 Findings include: On at 9:05 am. An observation showed that Resident 7 was crying while lying in bed with all side rails raised. The resident appeared visibly distressed, and the room temperature felt . The resident's breakfast tray, which included oatmeal and applesauce, had been placed on the table out of the resident's reach. Further observation revealed that the food was to the touch. On at 7:55 am. During an interview, Resident 11 complained about the quality of the food provided at the facility, stating, "The food here is terrible. "I have lost since I've been here." On at 8:24 am. During an interview, Resident 23 stated that the food was sometimes not great." On at 9:11 am, Staff L (Certified Nursing Assistant) stated that hospice provided the breakfast and lunch to the residents. She further stated that the food came from the facility's kitchen, and not from hospice. Class III	A 093		
A 152 SS=F	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to	A 152		

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A 152	Continued From page 47 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 failed to provide a safe environment, free from hazards. The facility also failed to ensure that all architectural, mechanical, electrical, and	A 152		

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A 152	Continued From page 48 structural systems and related components were maintained in proper working conditions. Empty and unmonitored units under construction were accessible to residents. Findings include: A review of the facility census on showed 307 residents in occupancy. On at 6:05 am an observation showed one of three elevators out of service. Further observation revealed that the two working elevators were crowded with residents and staff waiting to travel from the ground floor throughout the facility's 14 floors. On at 6:57 am. An observation showed that had a rusty hot and -water valves. On at 6:59 am, observation showed in B a broken dresser drawer. On at 8:46 am, observation showed the stained carpet on floor 9 and floor 10, recliner chairs in the common area were peeling. On at 9:04 am, observation showed open construction area on at 9th floor. Further observation revealed that, while posted signs said 'danger, and 'work in progress', the door to the suite was not locked. On at 8:20 am, observation showed paint cans, and two plastic containers with white paint inside Resident 23's room. On at 8:25 am., Resident 23 stated	A 152		

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A 152	Continued From page 49 that he liked to paint his apartment, especially his closet. He affirmed that some of the paint had been provided by the facility's maintenance personnel. (Photographic evidence obtained) On at 7:23 am, observation revealed a live roach crawling on the wall in the hallway on the seventh floor. A review of the pest control records showed the last service date was with the target pest being treated for identified as the German cockroach. Class III	A 152		
A 160 SS=F	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if	A 160		

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A 160	Continued From page 50 applicable, a notation indicating that the resident was admitted with a ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to Rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in Rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in Rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by Section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 59A-36.007, F.A.C. (j) All food service records required in Rule	A 160		

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A 160	Continued From page 51 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.435, F.S., and rule Chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.; (q) The facility's prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.; (w) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by:	A 160		

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A 160	Continued From page 52 Based on Observation and record review the facility failed to record discharge addresses on the admission/discharge log. Findings include: A review of the admission-discharge log revealed no information about the discharge disposition address for any resident from - . (Photographic evidence obtained.) Interviewed on at 4:58 pm, the Administrator stated that she did not know a discharge address was required. Class III	A 160		
A 161 SS=E	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the	A 161		

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A 161	Continued From page 53 employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by Rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section 429.174, F.S., and Rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity , to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by Rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to maintain complete personnel records for	A 161		

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A 161	Continued From page 54 two of 20 sampled staff (Staff M and N). Findings included: A review of personnel files On . ' revealed no documentation of employment references for Staff M or Staff N (Caregivers). Interviewed on . , at 11:00 am, the Administrator stated that she didn't know references were required. Class III	A 161		
A 182 SS=H	59A-36.019(3) FAC Emergency Mgmt - Plan Implementation (3) PLAN IMPLEMENTATION. (a) All staff must be trained in their duties and are responsible for implementing the emergency management plan. New staff must be trained on the plan within 30 days of employment. (b) If telephone service is not available during an emergency, the facility must request assistance from local law enforcement or emergency management personnel in maintaining communication This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that five out of 24 sampled staff (Staff F, G, I, O, and Q) were trained in their responsibilities for the implementation of the emergency management plan. Findings include: A review of the facility census revealed an	A 182		

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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 182	Continued From page 55 occupancy of 307 residents. 1). An observation on at 10:45 AM, revealed that the facility had two fixed generators located outside, east of the main building near the outdoor patio area. During an interview on at 8:43 AM, Staff G (Maintenance Staff) was asked what the emergency procedures were if the generator did not start. He stated, "If it doesn't start, that is something for the supervisor" and further stated that he would call the supervisor. When asked what he would do if a fire broke out on the 4th floor, he stated that the generator would power one elevator and they'd take the wheelchairs down. When asked how he would take the residents who use a wheelchair down the stairs, Staff G stated he would carry the residents in a blanket down the stairs with three people. When asked if the facility had evacuation chairs, he asked, "What do you mean?" and then stated they have walkers and wheelchairs. During an interview on at 8:48 AM, Staff F (Certified Nursing Assistant) was asked to locate the generator, to which she asked, "For when the power goes out?'. Staff F walked over to the end of the hallway and pointed at the electrical panel room. She was informed that the generator was not located inside the electrical panel and was asked where in the facility the generator was. She stated that it was on the first floor, and when asked if she knew where on the first floor, she stated "No, I can't". During an interview on at 8:59 AM, Staff Q (Medication-Technician) was asked what she would do if the generator didn't start, she stated that the maintenance staff would take care	A 182		

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	AL11911395	A. BUILDING: _____ B. WING _____	03/30/2026

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A 182	Continued From page 56 of the lights of the building and they [care staff] would make sure that the residents are safe and that nothing would happen to them. A review of the Comprehensive Emergency Management Plan (CEMP) showed that "The following training procedure will be implemented to ensure that responding Facility staff are aware of how to operate the emergency power (alternate power source and cooling system in the Facility: Maintenance staff is trained upon hire and annually on emergency power equipment". It further revealed that "Describe below a training procedure for ensuring staff are aware of how to operate the emergency power in the facility and how new staff will be informed: All new staff is trained within 30 days of hire. All staff is trained annually as a refresher". 2). A review of the census dated revealed that the facility was a multi-story building with 14 floors and 307 residents. During an interview on at 8:53 AM, Staff F was asked if the facility had the evacuation chairs. Staff F stated that she didn't know what those were. Observation showed that Staff F walked into the nearest resident's room, opened the closet and pointed at a wheelchair. When asked how she would use the wheelchair to get the resident down the stairs, she stated that she would roll the wheelchair down the stairs. During an interview on at 9:39 AM, Staff I (Registered Nurse/Team Leader) was asked where the evacuation chairs were, to which he stated "Oh, it's over there" and pointed at the stairs.	A 182		

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A 182	Continued From page 57 In a subsequent interview on at 9:56 AM with Staff I, he was asked again if the facility has evacuation chairs, to which he stated, "We don't have". He was asked if the building was to become uninhabitable, what the emergency shelter locations were. He stated that they would have to go to the first floor. He was also asked what temperature would be too hot for residents to reside in the facility, to which he stated, "I think about 70 degrees". A review of the evacuation route maps and driving instructions revealed that the facility had two receiving facilities in the case of an evacuation. During an interview on at 10:27 AM with the Administrator when she was asked if the facility had evacuation chairs, she confirmed that they did not have any, and stated that the balconies accessible via resident rooms were designated safe areas from which residents could be rescued. A review of Staff I's employee record revealed that he completed training in Facility Emergency Procedures dated . 3). During an interview on at 10:59 AM, Staff O (Home Health Aide) was asked where the monoxide alarm was; she stated, "I don't know, I'm sorry". During an interview on at 11:02 AM, Staff Q was asked where the monoxide alarm was to which she laughed. She then entered a resident's room and pointed to the pull call cord.	A 182		

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A 182	Continued From page 58 During an interview on at 11: 09 AM, Staff G was asked where the monoxide alarm was. He stated that the smoke detectors were in the residents' rooms and then pointed to the smoke detector above him in the first-floor lobby. A review of the Comprehensive Emergency Management Plan (CEMP) showed that "The monoxide alarm(s) are located throughout the Facility in the specified locations: Location: Kitchen and Commercial Laundry - both on the 1st floor". Class II	A 182		
A 165 SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage;	A 165		

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A 165	Continued From page 59 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall	A 165		

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A 165	Continued From page 60 determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to submit an incident report to the agency for one out of 45 sampled residents (Resident # 1) who , , without being administered efforts immediately. Findings included:	A 165		

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A 165	Continued From page 61 A review of Resident #1's progress notes dated revealed that Resident #1 was found unresponsive in her room by Staff B (Certified Nursing Assistant) and the resident's daughter at approximately 9:45 PM. Staff B she called in an emergency to Staff C (Home Health Aide/ Team Leader). Once Staff C arrived, the resident's , was checked and he began . 911 was called and Staff C followed their instructions. An unidentified staff member brought in the and Staff C followed the instructions to operate the device. Rescue arrived approximately 15 minutes later; they continued to provide care to Resident #1 until she was pronounced at 10:45 PM. Further review of the resident's file did not show that the resident had a ( ) in place. During an interview with Resident #1's daughter on at 12:22 PM, the resident was last heard around 6 PM when she contacted her to advise her that she was not feeling well. During an interview on at 2:58 PM with Staff B, she was asked to recall what took place the night that she found Resident #1 was found unresponsive. Staff B stated that she opened Resident #1's room with a key because there was no answer; she was in attendance with the resident's daughter. When she discovered that the resident was unresponsive, she called the team leader, identified as [Staff C]. Staff B confirmed that she was trained; when asked why she did not immediately start , she stated because she "froze". She further stated that she had stepped out of the room, leaving Resident #1 and her daughter alone, because she heard something on the radio that she could not understand. She stated that she stepped out because the team leader had not arrived yet, so	A 165		

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A 165	Continued From page 62 she thought it could have been him. She stated that she thought she followed procedures when she called the team leader after the discovery. Staff B stated that she thought she did what she was supposed to do and if she had to do it now, she would not have waited for the team leader and would have started . She later confirmed that the last time she saw the resident was around :30PM and she never went to the resident's room for about eight hours. She stated that she would check on the independent residents, only at the beginning and end of her shift; she furthered that she normally does not do rounds for the independent residents A review of Resident # 1's health assessment completed on showed diagnosis of , type 2 , and . On the Physical or Sensory Limitations section stated, "Frail, Elderly." She was independent with activities of daily living. Progress notes from stated that Staff B had called the team leader, Staff C, via radio and found the resident in bed with her hanging off the side, the resident did not respond to verbal or physical stimulation, she was placed on the floor and was started following the dispatcher's instructions, the was brought to the room and team leader operated the device. Rescue personal arrived at 10:16 PM and the resident was declared at 10:45 AM. A review of the incident report database revealed no documentation of the occurrence at one or fifteen days. Class III	A 165		

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AL243	Continued From page 63	AL243		
AL243 SS=D	429.075(1) FS; 59A-36.011(9) FAC LMH - Training 429.075 (1) To obtain a limited mental health license, a facility must hold a standard license as an assisted living facility, must not have any current uncorrected violations, and must ensure that, within 6 months after receiving a limited mental health license, the facility administrator and the staff of the facility who are in direct contact with mental health residents must complete training of no less than 6 hours related to their duties. This designation may be made at the time of initial licensure or relicensure or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with this part, part II of chapter 408, and applicable rules. This training must be provided by or approved by the Department of Children and Families. 59A-36.011 (9) LIMITED MENTAL HEALTH TRAINING. (a) Pursuant to section 429.075, F.S., the administrator, managers and staff, who have direct contact with mental health residents in a licensed limited mental health facility, must receive the following training: 1. A minimum of 6 hours of specialized training in working with individuals with mental health diagnoses. a. The training must be provided or approved by the Department of Children and Families and must be taken within 6 months of the facility's receiving a limited mental health license or within 6 months of employment in a limited mental health facility. b. Training received under this subparagraph may	AL243		

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AL243	Continued From page 64 count once for 6 of the 12 hours of continuing education required for administrators and managers pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 2. A minimum of 3 hours of continuing education, which may be provided by the ALF administrator, online, or through distance learning, biennially thereafter in subjects dealing with one or more of the following topics: a. Mental health diagnoses; and, b. Mental health treatment such as: (I) Mental health needs, services, behaviors and appropriate interventions; (II) Resident progress in achieving treatment goals; (III) How to recognize changes in the resident's status or condition that may affect other services received or may require intervention; and, ( ) Crisis services and the procedures. 3. For administrators and managers, the continuing education requirement under this subsection will satisfy 3 of the 12 hours of continuing education required biennially pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 4. Administrators, managers and direct contact staff affected by the continuing education requirement under this subsection shall have up to 6 months after the effective date of this rule to meet the training requirement. (b) Administrators, managers and staff do not have to repeat the initial training should they change employers provided they present a copy of their training certificate to the current employer for retention in the facility's personnel files. They must also ensure that copies of the continuing education training certificates, pursuant to subparagraph (a)2. of this subsection, are	AL243		

Agency for Health Care Administration

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AL243	Continued From page 65 retained in their personnel files. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility that has a limited mental health component in its license failed to ensure that one out of 24 sampled staffs (Staff I) that had completed an 8 hours limited mental health training, had completed a 3 hours of continuing education in limited mental health topics within 2 years of having taken the initial training. Findings included: Record review of Staff I [Registered Nurse] revealed that he had taken 8 hours of limited mental health training on . Further review found no documentation of continuing education. On at 5:00 PM the Administrator stated that the record review was 'fine'. Class III	AL243		