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
	AL11969794	A. BUILDING: _____ B. WING _____	R 05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRABELLE	7400 SW 88TH ST MIAMI, FL 33156

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

AHCA Form 3020-0001

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

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CZ814	Continued From page 1 (d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic , submission to the Department of Law Enforcement. The registration must include the person ' s full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to update the status of employment on the Level 2 Clearinghouse database within 5 working days for one (Director of Nursing) out of 32 sampled employees who no longer worked at the facility. Findings: A review of the Level 2 Clearinghouse database showed that Staff C was listed as an active employee. Interviewed on at 1:15 PM when asked for the last day of employment for the Director of Nursing, the Assistant Executive Director stated that the last day of work was . . . Unclassified	CZ814		

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{A 000}	Initial Comments A second revisit survey was conducted at Mirabelle from through . The provider had deficiencies at the time of the survey. A Class I deficiencies were found at A0027 and A0055. A Class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is neccessary 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 I deficiencies began on and . Resident #28 complained for several days of , to the and was tranported to urgent care by his son where it was discovered the resident had four . Resident #32 swallowed unlocked medications left by an agency nurse intended for her husband and was rushed to the hospital, which resulted with elevated presssure, and hospitalized for two days. The facility's Administrator and Assistant Executive Director was notified on at 1:22 PM.	{A 000}		
A 027 SS=J	59A-36.007(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making . , and remind residents about scheduled . .	A 027		

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A 027	Continued From page 1 for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation. (c) The facility may not require residents to receive services from a , health care provider. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to make arrangements for health care for one (Resident #28) out of 48 sampled residents, after complaints of , in the for more than two days following discharge from the hospital. Resident #28 was transported to urgent care by son and was diagnosed with four . Findings: A review of Resident #28's urgent care records dated revealed: "patient one week ago and was seen at [hospital] family stated patient began with , to the right after being seen and treated. [Patient] is a 86-year male who presents to the urgent care complaining of right , . Patient reports that he when he lost his balance in the bathroom about 10 days ago. Patient reports that he was seen in the emergency room subsequently. However, he has been having right , since and he does not think he had of , for this area. Patient reports his , is currently a three out of 10 but reports that it is worse when he coughs takes a deep breath or twists or moves his right in any way making the , a "40 out of 10. Patient was taking , for the , but has not helped."	A 027		

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A 027	Continued From page 2 A review of emergency medical services records dated showed male in the bathroom and has right side and , post . Interviewed on at 9:29 AM when asked about his father's (Resident #28) , the son stated that he (Resident #28) had couple of . The Son stated on one of the , he (Resident #28). When asked how he found out about the and when it occurred, the son stated that he believed that it was the on where he (Resident #28) his . The Son stated that when Resident #28 , he (Resident #28) in the bathroom. The son stated that it ( ) was not detected on . The son stated, "He (Resident #28) complained of , to me. He was in so much , . I took him to urgent care, and the was found." The son stated that he (Resident #28) was in , for two days. Interviewed on at 10:00 AM the Wellness Nurse stated that Resident #28 was found in the bathroom. The Wellness Nurse stated that he complained of , when she (Wellness Nurse) placed her on his . The Wellness Nurse stated that when Resident #28 returned ( ) from the hospital that he (Resident #28) did not complain to the employees. The Wellness Nurse stated that Resident #28 would rely on his son a lot. Interviewed on at 11:14 AM Staff R (Resident Assistant) stated that it was around 1:00 AM-2:00 AM when Resident #28 was found on the floor. Staff R stated that Resident #28 was on his . When asked about Resident #28's , Staff R stated that she did not	A 027		

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A 027	Continued From page 3 know anything about it. Staff R stated, "I guess he had a . A review of Resident 28's health assessment dated showed a diagnosis of Prostatic Hyperplasia ( ). The physical status showed unable to walk and wheelchair bound. The status showed normal. The resident had prevention precautions. The resident needed assistance in ambulation, bathing, , eating, self-care, toileting, and transferring. Interviewed on at 1:22 PM the Administrator stated, "Thank you." The Cleveland Clinic states: " can be caused by everything from a to a major , if you don't have any other internal injuries, you will probably be able to recover at home with over-the-counter medicine, icing and breathing exercises. A s the medical term broken . Rib are usually caused by care accidents, sports injuries or other . It can be cause by . Your are some of the strongest bones in your body, so it's rare to a without experiencing a major like a car accident or . Go to the emergency room if you experience any of the following: intense , . You have trouble breathing. You can't move part of your body that you normally can." The Mayo Clinic pian measurement scale revealed: "mild , 1 to 3 (nagging or annoying but does not interfere with daily activities), moderate , 4 to 6 (interferes with daily activities) Ranges from distracting , that can only be ignored for periods of time to difficulty concentrating, and severe , 7 to 10 (disabling	A 027		

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A 027	Continued From page 4 or unable to carry out normal daily activities) Ranges from impacts your relationships, or sleep to being bedridden or even delirious. Class I	A 027		
{A 030} SS=H	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents	{A 030}		

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{A 030}	Continued From page 5	{A 030}		

and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and , ;
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and standard precautions;
8. The requirements for coordinating the delivery of services to residents by third party providers;
9. Assistive devices; and
10. Physical .
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where

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{A 030}	Continued From page 6 residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as	{A 030}		

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{A 030}	Continued From page 7 provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with	{A 030}		

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{A 030}	Continued From page 8 relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility	{A 030}		

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{A 030}	Continued From page 9 must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure three (Residents #31, #35 and #48) out of 48 sampled residents live in a safe and decent living environment, free from and neglect, and treated with consideration and respect and privacy. The facility failed to protect and prevent Residents #35 and #48, including residents not named from and aggressive behavior during their stay in the facility by Residents #6 and #30.	{A 030}		

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{A 030}	Continued From page 10 Findings: 1) Interviewed on at 10:48 AM when asked about Resident #30, the Wellness Nurse stated that Resident #30 had episodes. The Wellness Nurse stated that her (Resident #30) husband (Resident #13) was afraid of her. The Wellness Nurse stated that Resident #30 would go into other residents' rooms. The Wellness Nurse stated that a few weeks ago, Resident #30 got aggressive with a staff. The Wellness Nurse stated, "When her (Resident #31) husband would talk to other women residents, Resident #30 would get aggressive with him (Resident #31). When asked how long Resident #30's behavior was going on, The Wellness nurse stated that since she (Wellness Nurse) has been working in the facility and that it has become worse lately. The Wellness Nurse stated, "She Resident #30) struck residents. When asked for names of residents, the Wellness Nurse stated that she does not remember but mentioned only Resident #35's name. However, there was no documentation of Resident #30 striking Resident #35 in her (Resident #30) progress notes. A review of Resident #35's progress notes showed no documentation of the resident being struck or by Resident #30. Interviewed on at 11:24 AM When asked about Resident #30, Staff R (Resident Assistant) stated that the resident could be combative. Staff R stated that the first time she (Staff R) worked, Resident #30 chased her down the hallway. Staff R stated, "She could be combative if you get close to her, but mainly with	{A 030}		

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{A 030}	Continued From page 11 her husband." Interviewed on at 6:09 AM Staff K (Licensed Practical Nurse) stated that Resident #30 was hospitalized for being combative. A review of Resident #30's health assessment dated showed diagnoses of of , , acute , injury, . The physical status ambulates with assistance, needs assistance with activities of daily living. The status showed alert, disoriented but follows commands. A review of Resident #35's health assessment dated showed a diagnosis of and . The status showed awake, alert and oriented times one. 2) A review of Resident #6's progress notes dated revealed: "Resident attempted to get up several times using the couches closet to the patio doors and hit another resident [Resident #48] and in a fit of agitation began continued hitting staff. Nurse on shift contacted the power of attorney for Resident #6 as well as the police and paramedics regarding this situation." Interviewed on at 1:22 PM the Administrator stated, "Thank you." A review of the facility's census posted on the board showed Resident #6 remained in the facility and accessible to other residents. A review of criteria for continued residency and discharge policy shows revealed that a resident is	{A 030}		

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{A 030}	Continued From page 12 to be discharged if the resident is a danger to self and others. A review of Resident #6's health assessment dated showed a diagnoses of 's , on , , , , , . The status showed 's . The activities of daily living showed assistance needed with ambulation, bathing, , toileting, self-care, transferring and independent with eating. Class II	{A 030}		
{A 033} SS=D	59A-36.007(8) PHYSICAL (8) PHYSICAL . Residents for whom a physician has prescribed a physical must have a written care plan for the use of the physical . The care plan must be developed within 14 days of the device being prescribed, and prior to use on the resident. (a) The care plan must specify: 1. The device prescribed for use; 2. The maximum amount of time the resident is to have the applied each day; and, 3. In what manner and frequency staff will monitor, observe, and report to the physician any injuries, increase in agitation, signs and symptoms of , , or decline in mobility or function related to the use of the prescribed . (b) Facility staff must ensure that the device is applied appropriately and safely. (c) The resident's physician must review the appropriateness of the continued use of the physical annually, and documentation of	{A 033}		

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{A 033}	Continued From page 13	{A 033}		

this review must be maintained in the resident's record. If the resident's ability to independently remove or avoid the device fluctuates, the device must be considered a physical and all requirements of this subsection apply.

This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to have a care plan for the use of for two (3) out of 48 sampled residents (Resident # 27, # 43 and # 44).

Findings included:

Observation on at 9:12 AM showed Resident # 43 in bed with half side rails up. prescription . Consent . No care plan for the use of .

Observation on at 9:14 AM showed Resident # 27, in bed with half side rails up.

Observation on at 9:20 AM showed Resident # 44, in bed with half side rails up.

A review of Residents # 27, # 43 and # 44 records showed that all three residents were under hospice services, Resident # 27 and # 43 required total assistance with activities of daily living and Resident # 44 required assistance with ambulation, eating and transferring and total assistance with bathing, , grooming and toileting. Record review also showed that Residents # 27, # 43 and # 44 had no care plan for the use of physical .

On at 1:13 PM during the exit conference the Director of Memory Care stated

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{A 033}	Continued From page 14 that she had the care plans for the use of physical but did not provide them when requested. Class III	{A 033}		
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.	A 052		

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A 052	Continued From page 15 (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the	A 052		

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A 052	Continued From page 16 reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with	A 052		

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A 052	Continued From page 17 medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview the failed to follow the state's guidelines when assisting two out of 48 sampled residents (Resident # 45 and # 46) with self-administration of medications.	A 052		

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A 052	Continued From page 18 Findings included: Observation on at 7:23 AM showed Staff F assisting Resident # 45's with self-administration of medications, Staff F failed to state the dosage of the medications. Observation on at 7:32 AM showed Staff F assisting Resident # 46's with self-administration of medications, Staff F failed to state the dosage of the medications. A review of Residents # 45 and # 46's records showed that there were no medications waiver. On at 1:11 PM the Director Memory Care acknowledged that Residents # 45 and # 46 did not have a medication waiver. Class III	A 052		
{A 055} SS=J	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:	{A 055}		

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{A 055}	Continued From page 19 1. The facility administers the medication; 2. The resident requests central storage. The 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	{A 055}		

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{A 055}	Continued From page 20 has not expired must be returned to the resident or the resident's representative, as appropriate, 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 on observation, record review and interview, the facility failed to secure or lock prescribed medications for one (Resident #33) out of 48 sampled residents, which resulted in a medication error. Resident # 32 took the medication intended for Resident # 33 and consequently, Resident #32 was hospitalized	{A 055}		

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{A 055}	Continued From page 21 fortwo days for elevated , . The facility also failed to lock the medication cart which was left unattended and accessible to residents. Findings included: 1- A review of the AHCA Incident Report System (AIRS) showed an incident report due to a medication error at the facility in which Resident # 32 took a medication intended for her husband (Resident # 33). A review of Resident # 32's health assessment, dated , the Physician had the Resident diagnosed with , , , , , , of Left , , and , and she required assistance with self-administration of medications. On at 11:19 AM Staff T [License Practical Nurse] stated on interview he was working when the License Practical Nurse from the home health agency left the medication in the room. He stated, "I was working on the memory care floor. I noticed she was behind. When I went to the med pass, she was running late. She told me she made a mistake. I told her to go to the apartment to get the medication. She told me that the resident did not want to give the medication and took the medication. I called the nurse. I have no idea how she left the medication. A review of the hospital record dated , showed that Resident # 32 had been admitted with a diagnosis of accidental medication error. Further review show that the resident had been	{A 055}		

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{A 055}	Continued From page 22 given , 225 mg accidentally by staff at the senior living center 2 hours prior. At the emergency department triage her , was (Hi) (Sic). According to Mayo Clinic normal , values are below mmHg and diastolic 80 mmHg, elevated , values are 120-129 mmHg and diastolic below 80 mmHg, 130-139 mmHg or diastolic 80-89 and or higher or diastolic 90 or higher. High can lead to complications including , changes in memory or understanding, or , aneurism, problems, problems and . According to Mayo Clinic is used to prevent irregular heartbeats such as (AF) from occurring again in patients who do not have structural . There is a chance that may cause new or make worse existing rhythm problems when it is used. Since it has been shown to cause severe problems in some patients, , is only used to treat serious rhythm problems. This medicine can cause changes in your rhythm, such as conditions called PR, QRS, or QT prolongation. It may cause fainting or serious side effects in some patients. 2- Observation on at 7:23 AM showed Staff F left medication cart unlocked and unattended in the hallway while she went into Resident # 45's room to see if he wanted his medications (photographic evidence obtained). A review of the facility medications policy and procedure showed:	{A 055}		

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{A 055}	Continued From page 23 Policy: Medication will be managed for those residents who need assistance in compliance with all relevant state regulations and corporate standards. Procedure for storage: 4. Medications will not be pre-poured or left unattended by an employee. 5. When not in use, the medication cart will be locked and stored in the wellness center or designated area and inaccessible to residents. On at 1:17 PM the Director of Memory Care stated that all staff had been recently trained. Class I	{A 055}		
A 077 SS=G	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an	A 077		

Agency for Health Care Administration

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A 077	Continued From page 24	A 077		

administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule.
(5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years.

59A-36.010
(1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter.
(a) An administrator must:
1. Be at least ;
2. If employed on or after , have, at a minimum, a high school diploma or G.E.D.;
3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.;
4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to , are not required to take the competency test unless specified elsewhere in this rule; and,
5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect

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A 077	Continued From page 25 on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as	A 077		

Agency for Health Care Administration

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	AL11969794	A. BUILDING: _____ B. WING _____	R 05/15/2026

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A 077	Continued From page 26 a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that it was under the supervision of an Administrator who provided appropriate care of all residents. The Administrator failed to make health care arrangements for Resident #28 who remained in the facility with a in , for two days. The Administrator failed to maintain a written record updated as needed of a significant change for Resident #28 who was not taking baths. The administrator failed to ensure the employees were effectively trained in the emergency plan and assistance with self-administration of medication training and prevent medication errors. The facility Administrator failed to file two adverse incidents which resulted in Resident #34 placed under and a police investigation of an on Resident #48 by Resident #6. Findings: Interviewed on at 9:29 AM the Son of Resident #28 stated that his father (Resident #28)	A 077		

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A 077	Continued From page 27	A 077		

complained for two days to him (Son) after returning from the hospital on of , to his (#28) . The son stated that he took his father to urgent care and that was when he (Son) found out that his father (Resident #28) four .

Interviewed on at 11:14 AM Staff R (Resident Assistant) stated that stated that she did not know anything about Resident#28 .

Interviewed on at 10:00 AM the Wellness Nurse stated that she (Wellness Nurse) was there when Resident #28 was found on the bathroom floor on . The Wellness Nurse stated Resident #28 complained of , when she (Wellness Nurse) placed her on his (Resident #28) The Wellness nurse stated that when he (Resident #28) returned from the hospital that he did not complain to the employees. She stated that Resident Frank would rely on his son a lot.

A review of Resident #35's progress notes, there was no documentation of the resident being physically by Resident #30 although shared by the Wellness Nurse in an interview.

A review of Resident #28's progress notes, there was no documentation of the resident's refusal to be provided with a bath and for how long.

A review of the facility's records found no plans submitted as required to hire a pharmacist or nursing consultant to address uncorrected medication errors, including an error that resulted in a 911 call for Resident #32, and to address multiple residents' with serious injuries.

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A 077	Continued From page 28 A review of Resident #48 progress notes revealed Resident #48 was by Resident #6 and the police were called and Resident #34 progress notes found the resident (#34) was placed under . However, the Administrator failed to file adverse incident reports as required for incidents which involved police investigations. Interviewed on at 6:36 AM when asked for the facility's census and how many residents were in the hospital, Staff M (Concierge) at the front desk stated that he did not know and that information would be upstairs. Interviewed on at 6:30 AM when asked for the facility's census, Staff AE (Concierge) at the front desk did not know the census of the facility. Interviewed on at 7:22 AM the Assistant Executive Director stated that the concierge would not know or have that information. Interviewed on at 1:22 PM when informed of the deficiency, the Administrator stated, "Thank you." A review of the Administrator's personnel records showed a hire date of . Class II	A 077		
A 093 SS=G	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	A 093		

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A 093	Continued From page 29 and available for review at: http://www.flrules.org/Gateway/reference.asp?No =Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_ Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of	A 093		

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A 093	Continued From page 30 comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals.	A 093		

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A 093	Continued From page 31 (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 record review and interview, the facility failed to follow a prescribed therapeutic diet approved by a health care provider for one (Resident #30) out of 48 sampled residents immediately discharged from the hospital. Findings: A review of Resident #30's progress notes dated at 10:44 PM showed Resident #30 returned from the hospital at approximately 4:20 PM. A review of Resident #30's progress notes dated revealed at 11:04 PM: "the resident was offered a puree diet today as per orders but refused it. She was given beef, rice, and vegetables and ate the majority of her dinner without any issues. [Memory Care Director] was notified about this, and the diet will be updated as	A 093		

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A 093	Continued From page 32 needed post-hospitalization." Interviewed on at 10:48 AM when asked why regular meal was served to Resident #30 instead of a puree meal, the Wellness Nurse stated that the last time she (Resident #30) was hospitalized, Resident #30 came on a puree diet. The Wellness Nurse stated that there was a prescription. However, the facility failed to produce the prescription for a puree diet and explain why the puree diet was discontinued without an order. Interviewed on at 11:30 AM when informed that the facility was going to be cited for not having the prescription for a puree diet for Resident #30, the Memory Care Director stated that she called the doctor's office and that she had the health assessment but not the prescription. A review of Resident #30's health assessment dated showed diagnoses of , agitation, , lower , and . The physical status showed . The status showed unspecified , spectrum. The special diet instructions showed puree, blenderized diet. According to the New Jersey Department of Human Services Division of , revealed that a puree is a modified diet with no measurable size that is creamy and smooth. A person on a puree diet may have significant issues. Pureed food should not have any texture or lumps. When using a blender or a food processor to get the food smooth, it is necessary to add liquids to achieve the correct consistency. If you use water or milk,	A 093		

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A 093	Continued From page 33 the food will be bland and tasteless. Broth and seasoning are recommended to ensure the food is flavorful. Interviewed on at 1:22 PM the Administrator stated, "Thank you." Class II	A 093		
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 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	A 160		

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A 160	Continued From page 34 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 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	A 160		

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A 160	Continued From page 35 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: Based on record review and interview, the facility failed to maintain an admission and discharge log with the date of admission, the facility or place from which the resident was admitted from for 48 out of 48 sampled residents. In addition to the admission and discharge log, the facility failed to maintain the date of discharge, reason for discharge, and identification of the facility or	A 160		

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A 160	Continued From page 36 home address to which any resident was discharge to. Findings: A review of the facility's records found no admission and discharge log for a census of 89 residents. Interviewed on at 10:50 AM when asked for the admissions and discharge log, the Memory Care Director stated they had a list. The Memory Care Director stated, "This was the list when a resident signs out and returns to the facility. However, a sign in, sign out log was presented. Class III	A 160		
{A 162} SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable.	{A 162}		

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{A 162}	Continued From page 37 (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A ⌣ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their ⌣ recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that ⌣ not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff,	{A 162}		

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{A 162}	Continued From page 38 or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this	{A 162}		

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	AL11969794	A. BUILDING: _____ B. WING _____	R 05/15/2026

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{A 162}	Continued From page 39 arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to maintain an updated and accurate health assessment for two (Residents #6 & #28) out of 48 sampled residents. Findings: 1) A review of Resident #28's health assessment dated showed in section 1 the resident's information was missing and the nursing status left blank and the health assessment not updated after on and . The nursing status was left blank. 2) A review of Resident #6's progress notes dated showed the resident (Resident #6) had a , hit staff and Resident #48, and on Resident #6 became agitated with physical aggression. However, a review of	{A 162}		

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{A 162}	Continued From page 40 Resident #6's health assessment dated showed that the resident's health assessment was not updated after and aggressive behavior. Interviewed on at 1:01 PM the Assistant Executive Directors the names of the residents with incomplete and inaccurate health assessments. Class III	{A 162}		
{A 182} SS=D	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 record review and interview, the facility failed to ensure three (Assistant Executive Director, Wellness Nurse, Staff N Resident Assistant) & out of 30 sampled employees were trained in their duties and are responsible for implementing the emergency management plan. Findings: 1) Interviewed on at 6:45 AM when	{A 182}		

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{A 182}	Continued From page 41 asked how long she worked in the facility, Staff N (Resident Assistant) stated that she worked on the overnight shift and has been employed for six months. Staff N stated that she was assigned to floors . When asked how many residents she was responsible for, Staff N was unable to provide an answer. When asked how she would evacuate the facility in the event of an emergency, Staff N was unable to describe. Staff N stated further that the agency staff was making her nervous. A review of the census posted on the board showed a census of 91 residents and two out of the 91 residents in the hospital. A review of the staff schedule dated for the 11:00 PM-7:30 AM shift showed Staff N of shift. 2) Interviewed on at 6:52 AM when asked for the facility census, the Wellness Nurse was unable to describe. A review of the staff schedule dated for the 7:00 AM-3:30 PM shift showed the Wellness Nurse in charge of the shift. 3) Interviewed on at 7:49 AM when asked about the generator, the Assistant Executive Director stated that the generator was tested every Tuesday at 10:00 AM. When asked to manually start the generator, the Assistant Executive Director stated, "I don't know how to manually start the generator." When asked how many hours of fuel is required be stored, the	{A 182}		

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{A 182}	Continued From page 42 Assistant Executive Director stated, "72 hours." A review of the facility's emergency power plan showed 98 hours of runtime fuel onsite. In the event of a power outage, the plan revealed: "2,712 square of cooled space. The care team will relocate 22 residents on 8th floor and 72 residents on 9th floor dining/activity room. This I based on full occupancy. The residents on the 8th floor are located in the same hallway were the cooling area is located. They will be transported by the care team to the cooling area based on care plan and the condition of the residents at the moment. For the 9th floor the care team will relocate the residents to the cooling are based on their care plan and the condition of the resident at the moment." Interviewed on at 11:37 AM the Maintenance Director stated that he had 96 hours of diesel fuel. The Maintenance Director stated that he (Maintenance Director) trained the employees repeatedly about the generator's fuel. The Maintenance Director stated that he had one 660-gallon sub tank and a 2,200-gallon stand-alone tank. Class III	{A 182}		
{A 058} SS=F	429.42( ) FS; 58A-5.033(3)(a) FAC Pharmacy & Dietary; Uncorrected Deficiencies 429.42 Pharmacy and dietary services.- (1) Any assisted living facility in which the agency has documented a class I or class II deficiency or uncorrected class III deficiencies regarding medicinal drugs or over-the-counter preparations, including their storage, use, delivery, or administration, or dietary services, or both, during	{A 058}		

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{A 058}	Continued From page 43 a biennial survey or a monitoring visit or an investigation in response to a complaint, shall, in addition to or as an alternative to any penalties imposed under s. 429.19, be required to employ the consultant services of a licensed pharmacist, a licensed registered nurse, or a registered or licensed dietitian, as applicable. The consultant shall, at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required. (2) A corrective action plan for deficiencies related to assistance with the self-administration of medication or the administration of medication must be developed and implemented by the facility within 48 hours after notification of such deficiency, or sooner if the deficiency is determined by the agency to be life-threatening. 58A-5.033(3) (3) EMPLOYMENT OF A CONSULTANT. (a) Medication Deficiencies. 1. If a class I, class II, or uncorrected class III deficiency directly relating to facility medication practices as established in Rule 58A-5.0185, F.A.C., is documented by the agency pursuant to an inspection of the facility, the agency must notify the facility in writing that the facility must employ or contract the services of a pharmacist licensed pursuant to Section 465.0125, F.S., or registered nurse as determined by the agency. 2. After developing and implementing a corrective action plan in compliance with Section 429.42(2), F.S., the initial on-site consultant visit must take place within 7 working days of the notice of the class I or II deficiency and within 14 working days of the notice of an uncorrected class III deficiency. The facility must have available for review by the agency a copy of the license of the	{A 058}		

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{A 058}	Continued From page 44 consultant pharmacist or registered nurse and the consultant's signed and dated review of the corrective action plan no later than 10 working days subsequent to the initial on-site consultant visit. 3. The facility must provide the agency with, at a minimum, quarterly on-site corrective action plan updates until the agency determines after written notification by the consultant and facility administrator that deficiencies are corrected and staff has been trained to ensure that proper medication standards are followed and that such consultant services are no longer required. The agency must provide the facility with written notification of such determination. This Statute or Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to correct a Class III deficiency regarding medications storage and disposal, and also was cited in assistance with self-administration of medications and is required to retain the services of a registered nurse or a licensed pharmacist to conduct no less than quarterly consultations until the Agency determines such services are no longer needed. Findings included: A review of the facility's survey history revealed that on and the facility was cited A-0055- Medication-Storage and Disposal, in addition the facility was cited once again A-0055 on and also cited A-0052-assistance with self-administration of medications. A review of the AHCA Incident Report System (AIRS) showed an incident report due to a	{A 058}		

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{A 058}	Continued From page 45 medication error at the facility in which Resident # 32 took a medication intended for her husband (Resident # 33), Resident # 32 had to be transferred to the hospital where she was admitted for 2 days with high , . On at 10:30 AM Staff J stated that Resident # 32 took the medications of the husband in error and stated that the error occurred at 8:30 PM by an agency nurse that was new working at the facility, she had left the medication for Resident # 33 in the room, even thought Resident # 33 was not in the room. When the agency nurse went to retrieve the medication, Resident # 32 had swallowed the medication. Observation on at 7:23 AM showed Staff F getting inside Resident # 45's room leaving the medication cart unlocked. Observation on at 7:23 AM showed Staff F assisting Resident # 45's with self-administration of medications, Staff F failed to state the dosage of the medications. Observation on at 7:32 AM showed Staff F assisting Resident # 46's with self-administration of medications, Staff F failed to state the dosage of the medications. A review of Residents # 45 and # 46's records showed that there were no medications waiver. On at 11:18 PM the Director of Memory Care stated that they will renew the contract with the pharmacyst to come trained the staffs agin. Class II	{A 058}		

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{A 078}	Continued From page 46	{A 078}		
{A 078} SS=E	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . 2. If any staff member has, or is suspected of 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	{A 078}		

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{A 078}	Continued From page 47 responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide documentation of an annual negative ( ) examination for one out of 29 samples staff (Staff F) and the facility failed to ensure that two out of 29 sampled staff knew the facility elopement policy (Staff N and Staff V) Findings included: 1)	{A 078}		

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{A 078}	Continued From page 48 A review of Staff F 's (Medication Technician) employee record revealed the last negative examination was completed on . During an interview on / 2026 at 1: 05 PM Staff B (The Assistant Executive Director) stated that the statement was in the employee's file. During an interview on at 1:10pm Staff Q (The Memory Care Director) stated that Staff F had it done last month, but the statement was not documented in the file. 2) During an interview on at 6:45am Staff N (resident assistant) stated that she had been working that the facility for about six months. Staff N did not know of any elopement and did not answer when asked about the facility elopement procedure. A review of Staff N 's employee records showed that she received training on elopement on . A review of the facility elopement drill policy showed that "all employees would receive elopement drill education during the initial orientation and at least annually thereafter." During an interview on at 6:28am Staff V (medication technician) stated that there had been no elopements. Staff V stated that if an elopement happened, she would search for the resident, but if the resident was not found did not know what to do. A review of the facility policy showed fifteen procedures to follow if the residents were not	{A 078}		

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{A 078}	Continued From page 49 found. A review of the facility incident logs showed that on Resident # 29 and out of the facility without supervision. Class III	{A 078}		
{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; 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	{A 165}		

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{A 165}	Continued From page 50 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 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	{A 165}		

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{A 165}	Continued From page 51 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 report adverse incidents for three out of 48 sampled residents (Resident # 1, Resident # 6 and Resident # 34). Findings included: A review of the Adverse Incident Reporting System (AIRS) revealed no incident report filed within 15 days of the facility's investigation into Resident # 1 's on . During an interview on at 11:20am Staff J (Wellness Nurse) stated that Resident #34 was taken by police on after stating that she wanted to kill herself.	{A 165}		

Agency for Health Care Administration

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{A 165}	Continued From page 52 A review of Resident # 34's records showed that during a medication pass on the morning of . . . . . Resident #34 expressed to the medication tech that she wanted to k ill herself and that she was not happy living in the community. Police were called and the resident was taken to the hospital. A review of Resident # 6's records showed that on police were contacted when the resident repeatedly hit, shoved and pulled the hair of staff and hit Resident # 48. A review of the Adverse Incident Reporting System (AIRS) revealed no incident report filed regarding Resident # 34 or Resident # 6 after the incidents. Class III	{A 165}		