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
	AL11970300	A. BUILDING: _____ B. WING _____	R 05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELMONT VILLAGE CORAL GABLES	4111 SALZEDO ST CORAL GABLES, FL 33146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
ZZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the , , are enrolled in the national retained print notification program at the Federal Bureau of Investigation: 1. A person with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. 2. Effective , , , or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity. (c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse. 1. Before , , , initial status and any changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person ' s status has been made. 2. Effective , , , initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person ' s status has been made.	ZZ814		

AHCA Form 3020-0001

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

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ZZ814	Continued From page 1 (d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic ˬ , submission to the Department of Law Enforcement. The registration must include the person ' s full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to maintain an accurate and up-to-date employee roster for personnel in the background screening clearinghouse database for one out of 37 sampled staff (The Administrator). Findings include: During an interview on at 7:32 AM, the Administrator introduced himself as the administrator of the facility. A review of the facility's employee roster in the background screening clearinghouse database revealed that the facility's former administrator was still listed as the current administrator with no end date. A review of the Florida Health Finder database, revealed that the Administrator was reported as the facility's administrator.	ZZ814		

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ZZ814	Continued From page 2 Uncorrected Unclassified	ZZ814		

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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 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 record review and interview, the facility failed to ensure that there was a written order, consent, and care plan for the use of a physical for two out of 41 sampled residents. (Resident #1 and Resident #17) Findings include: A review of Resident #1's record revealed Resident #1 did not have a consent or care plan for bed rails.	A 033		

AHCA Form 3020-0001

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A 033	Continued From page 1 During an interview at 10:57 AM Staff HH (Director of Resident Care) stated Resident #17's "doctor gave and place an order for bed rails, and the bed rails were installed last week." A review of Resident #17's record revealed Resident #17 did not have a care plan for bed rails. Uncorrected Class III	A 033		

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{A 000}	Initial Comments A re-visit to a complaint investigation (#2025014832, #2025017060, & #2025017213) was conducted at Belmont Village Coral Gables from through . The Facility had deficiencies identified at the time of survey.	{A 000}		
{A 025} SS=G	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	{A 025}		

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{A 025}	Continued From page 1	{A 025}		

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, 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 review and interview the facility failed to provide adequate supervision and ensure the health, safety and physical and/or mental wellbeing for three out of 42 sampled residents (#17, #38 and #40) who had repeated in facility. The facility failed to implement effective measures to prevent the repeated of Residents #17, #38 and #40.

Findings as follow:

1. A review of Resident 17's progress notes showed:
On at 04:00 pm the resident was

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{A 025}	Continued From page 2 found on the floor getting to bathroom. On at 10:06 the resident was found lying on floor next to bed. On at 23:30 Resident observed in bedroom sitting on the floor. On at 08:00 Resident's husband went to wellness center to report Resident #17 was on the floor in the room. On -no time recalled resident was found in her bedroom's floor by her caregiver. On - 18:16- Resident assessed following a . at 4.36 pm resident returned to facility from doctor following a from bed. with a diagnosis of T-12-L . On at 11:00 resident was observed on floor after being assisted by her caregiver. On at 05:10 resident was bserved on the floor near bathroom. On at 02:15- Private caregiver called the nurse to assess resident after a . Small noted on left . On at 08:40 the resident observed on the floor besides the of the bed after being alerted by caregiver. at 5PM the Facility's Wellness center was alerted that resident and her husband were found outside of the building. Resident had and she was evaluated by . A review of Resident #17's Assessment dated showed the resident was diagnosed with , , , , , , , complicated , , HO: , , Valve , , , . Dd not have physical or sensory limitations, had advanced and needed assistance with all Activities of daily living. The resident was not under special precautions for .	{A 025}		

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{A 025}	Continued From page 3	{A 025}		

2. A review of Resident #38 progress notes showed:
On the resident slided off the couch in her living room, she was found sitting on her , no injuries.
On the resident lost her balance walking out of the living room and , no injuries
On the resident was found on the floor at the of her bed, daughter stated that she was helping her mother to try on some pants while she was sitting at the edge of her bed, resident began to slip down from the bed and daughter assisted her to the floor, no injuries.
On the resident was found on the floor, sitting in lotus position with extended out, .

A review of Resident #38 Health assessment dated showed a diagnosis of status post , cavernous hemangioma, of , history of , status post BSO + Chemo in 1990, pre , primary of the , mild 1 positivity, major precautions topic was not completed. Resident was independent with the activities of daily living, nursing/treatment/ services, physical or sensory limitations, and special precautions were left blank.

3. A review of Resident #40 progress notes showed:
On at 18:05- resident from wheelchair in apartment, no visible injuries noted, 911 called, refused to go to the hospital. stated that she was trying to go to her bedroom for her remote control. She was placed into wheelchair and instructed to call for help.
On at 5:00 PM- resident observed on

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{A 025}	Continued From page 4 the floor in her apartment, stated that she slid to the floor, no injuries noted. Physicians and family notified. On (no time)- resident found on the floor with 2 PALs beside her. PALs stated the was assisted. Resident slid from bed. On at 7:15 AM- resident slid to the floor from the wheelchair, resident was observed on the floor next to her bed with PAL beside her with the wheelchair. Denied , . She was picked up and place in wheelchair. On at 6:05 PM- observed in apartment after , denies , or discomfort. A bump was found on the right side of the of her , bump is elongated and non-flat. Resident denies , upon palpation. Denies transport to hospital. On at 1330- resident found on the floor of Café, no found injuries. Assisted to wheelchair and taken to room. On 5:15 PM- observed on her apartment floor, no injuries, denies , or discomfort. A review of Resident #40's Health Assessment dated showed a diagnosis of , , , , type 2 , , and , the resident did not have Physical or sensory limitations, was alert and oriented, required assistance with the activities of daily living and she was not under special precautions. A review of the facility's policy stated " A resident care plan with individualized approach intructions will be developed by a nurse. Instructions and individualized interventions to help mitigate the risk of injury from will be included for those residents at risk. The Care plan should be updated with management interventions as appropriate."	{A 025}		

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{A 025}	Continued From page 5 On at 1:40PM the Director of Resident care stated the facility implemented preventive measures but residents continue falling. Class II	{A 025}		
{A 030} SS=E	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	{A 030}		

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{A 030}	Continued From page 6	{A 030}		

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

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{A 030}	Continued From page 7 telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, 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	{A 030}		

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{A 030}	Continued From page 8	{A 030}		

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

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{A 030}	Continued From page 9 Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names 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	{A 030}		

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{A 030}	Continued From page 10	{A 030}		

exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida.

429.27 Property and personal affairs of residents.-
(1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs.
(b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident.

This Statute or Rule is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure that it provided a 45-day discharge notice of relocation or termination of residency from the facility unless, for medical reasons, the resident was certified by a physician to require an emergency relocation to a facility providing a more skilled level of care. The facility further failed to have a readily accessible telephone on each floor of each

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{A 030}	Continued From page 11 building where residents reside. Findings include: 1). An observation on at 8:30 AM revealed that the telephone on the sixth floor was not operational. Further observation revealed that the phone was not plugged into a power source. 2). During an interview on at 11:52 AM, the Director of Resident Care was asked if there was a physician's order for discharge in Resident #2's record. She stated that if the document was not in the chart, then they did not have it because that was his entire chart. She further stated that if the resident required a , the family would have been informed that are not allowed at the facility and he would have required a higher level of care. A review of Resident #2's resident record revealed that there was no 45-day discharge notice or documentation from a physician that certified that the resident required a higher level of care. Uncorrected Class III	{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 033}		

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{A 033}	Continued From page 12 (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 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 record review and interview, the facility failed to ensure that there was a written order, consent, and care plan for the use of a physical restraint for two out of 41 sampled residents. (Resident #1 and Resident #17) Findings include: A review of Resident #1's record revealed Resident #1 did not have a consent or care plan for bed rails. During an interview 05/20/2026 at 10:57 AM Staff HH (Director of Resident Care) stated Resident #17's "doctor gave and place an order for bed rails, and the bed rails were installed last week." A review of Resident #17's record revealed	{A 033}		

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{A 033}	Continued From page 13 Resident #17 did not have a care plan for bed rails. Uncorrected Class III	{A 033}		
{A 052} SS=E	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	{A 052}		

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{A 052}	Continued From page 14 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 reason for administration requires judgment or	{A 052}		

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{A 052}	Continued From page 15 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 medication is away from the facility and from	{A 052}		

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{A 052}	Continued From page 16 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 facility failed to follow the state guidelines when assisting one out of 42 sampled residents (Resident # 12) with self-administration of medications. Findings included:	{A 052}		

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{A 052}	Continued From page 17 On at 7:19 AM Observed Staff BB [Med Tech] assisting Resident # 12 with self-administration of medications. Staff did not open the medications in front of the resident, she opened them on top of the medicine cart with a wall separating her from the resident, she poured the medications in 2 med cups, went in front of the resident, gave him one cup and told him, "This is your ." After the resident took the she handled him the other cup and stated, "And these are your routine meds, including the ." Staff BB did not say the dosage of all the medications and the names of the rest of the medications. A review of electronic records showed that Resident # 12 had the following medications: 5 mg twice a day. 20 mg daily. 75 mcg daily. 1 mg three times a day. 100 mg every 12 hours. 5 mg daily. On at 1:20 PM, the Director of Resident Care stated, "who was the med tech?"	{A 052}		
A 058 SS=D	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 biennial survey or a monitoring visit or an	A 058		

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A 058	Continued From page 18 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 consultant pharmacist or registered nurse and the	A 058		

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A 058	Continued From page 19 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 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 the facility was cited A-0052-assistance with self-administration of medications. The citation was found to be uncorrected during the revisit survey. On at 7:19 AM Staff BB [Med Tech] was observed assisting Resident # 12 with self-administration of medications and she did not open the medications in front of the resident, but on a separated area, she only told the resident the names of 2 medications and call the rest of	A 058		

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A 058	Continued From page 20 the medications routine, she did not tell the resident the dosage of any medications. On at 1:21 PM the Director of Resident Care stated that they will hire someone from outside to provide training. Class III	A 058		
{A 077} SS=D	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 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.	{A 077}		

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{A 077}	Continued From page 21 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 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	{A 077}		

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{A 077}	Continued From page 22	{A 077}		

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 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

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{A 077}	Continued From page 23 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 record review and interview, the facility failed to ensure that it was under the supervision of an Administrator who ensured and the provision of appropriate care of all residents. The Administrator failed to ensure an effective implementation of a intervention plan for Resident #17 after multiple undocumented and staff not knowing the census. Findings include: 1} A review of the internal incident log revealed Resident #17 had on , , , , , /226, and . A review of the adverse incidents reporting systems database found no reported of Resident #17 falling. A review of Resident #17's pal approach chart and service plan for , revealed the pal instructions are "check the resident prior to leaving encourage to ask for assistance when needed, pal to return frequently. Perform frequent wellness (, -on), uses a bedrail for safety and repositioning. Bed rail in the up position when the resident is in bed. Safety room checks with increased frequency due to risk."	{A 077}		

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{A 077}	Continued From page 24 A review of Resident #17's progress notes documented on revealed "resident was found lying on the floor next to bed, circumstances surrounding the were assessed; resident reported attempting to get out of bed prior to the incident." "Emergency medical services notified and responded." A review of Resident #17's progress notes documented on revealed "resident observed in bedroom sitting on the floor. "Resident was assisted from floor to bed." During an interview on at 10:57 AM, Staff HH (Resident Care Director) stated the doctor gave order for bed rails and doctor placed it in , , bed rail install last week. Staff HH stated that "if nothing is working, we will then have a conversation with resident's family suggesting a higher level of care." When asked what happened after physical and prevention no longer work for residents who had repeated . 2) During an interview at 6:21 AM Staff Y (Caregiver) stated she doesn't know the census. During an interview at 6:23AM Staff I (Caregiver) stated she was not aware of the census and that her phone is not working that would show her the census. Uncorrected Class III	{A 077}		

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{A 079}	Continued From page 25	{A 079}		
{A 079} SS=D	59A-36.010(3) FAC Staffing Standards - Levels	{A 079}		

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

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

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

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{A 079}	Continued From page 26	{A 079}		

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

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

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{A 079}	Continued From page 28	{A 079}		

minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs.
2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency.
(e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios.
(f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively.

This Statute or Rule is not met as evidenced by:
Based on interview and record review the facility failed to ensure that there was sufficient and adequate staffing available to meet the schedule and unscheduled residents. The facility only had one nurse (Staff FF), who was responsible for providing life saving measures for 97 residents, scheduled for the overnight shift.

Findings include:

During an interview on at 6:48AM, Staff I (Caregiver) was asked what she would do

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{A 079}	Continued From page 29 if she witnessed an unresponsive resident. She stated that "they" would not let her do , , , ( ). She further stated that she would wait for the nurse to provide . During an interview on at 8:54 AM, Staff K (Caregiver) was asked what she would do if she witnessed an unresponsive resident, to which she stated that she would call the nurse and wait for the nurse to provide . She confirmed that only the nurses could provide to the residents. A review of the staffing scheduled dated revealed that Staff FF (Licensed Practical Nurse) was the only nurse scheduled for 10:30 PM to 6:45 AM overnight shift. A review of the census revealed that on there was a census of 157 residents. A review of the Code Status documentation revealed that 97 of the 157 residents admitted would like to be provided with . Uncorrected Class III	{A 079}		
{A 160} SS=D	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	{A 160}		

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{A 160}	Continued From page 30	{A 160}		

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 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

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{A 160}	Continued From page 31 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 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.;	{A 160}		

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{A 160}	Continued From page 32 (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 ensure an up-to-date admission and discharge log listing date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Findings include: A review of the admission and discharge log address section revealed "unknown at this time and N/A." During an interview on at 1:19PM the Administrator stated, "is that new, we didn't have to do that before". When informed about the discharge addresses missing from the admission and discharge log. Uncorrected Class III	{A 160}		
{A 182} SS=D	59A-36.019(3) FAC Emergency Mgmt - Plan Implementation	{A 182}		

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{A 182}	Continued From page 33 (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 interview and record review, the facility failed to ensure that staff members were trained in the implementation of the emergency management plan within 30 days of employment. Findings include: On at 6:48 AM, during an interview, Staff I (Caregiver), hired on , indicated that she was not knowledgeable about the emergency plan and did not know the census. On at 1:19 PM During an interview Staff B (Executive Director), was informed that Staff I did not know the emergency plan, including evacuation sites. He responded, "They need to know exactly where?" He added that he believed only administrative staff knew the plan and stated that everything was in the Comprehensive Emergency Management Plan (CEMP). Record review of the New Employee Training Checklist showed on that Staff I received training on emergency management procedures. Class III	{A 182}		

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{A 078} SS=D	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 responsibilities, consistent with their	{A 078}		

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{A 078}	Continued From page 35 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 record review and interview, the facility failed to ensure Staff GG (Licensed Practical Nurse) and Staff and Staff FF had a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . Findings include: 1) A review of Staff GG employee file revealed Staff GG refused ( ) skin test.	{A 078}		

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{A 078}	Continued From page 36 A review of Staff GG employee file revealed Staff GG had an conducted on that stated "The is in normal size. There is no engorgement of the central vasculature. is . The are well aerated. There is no focal consolidation, , or , . The angles are clear. The regional bones are grossly unremarkable. No acute process is identified." However, the did not have a written statement from a health care provider that Staff GG was free of communicable . 2) A review of Staff FF employee file revealed Staff FF had an from . A review of Staff FF employee file revealed Staff FF had an expired free of communicable statement from a health care provider from . During an interview on at 1:19PM when informed about the skin test, the Administrator stated, "So it's the annual doctor statement, she declined?". Uncorrected 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	{A 165}		

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{A 165}	Continued From page 37	{A 165}		

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

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{A 165}	Continued From page 38 investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a 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	{A 165}		

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{A 165}	Continued From page 39 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 adverse incident report to the Agency for Health Care Administration (AHCA) within the required 15 business days, affecting 4 of the 42 residents sampled. Findings include: On at 8:45 AM, during an interview, Staff W (Caregiver) stated that she had been assisting Resident #40 to the bathroom. She reported that she had hurt her while helping the Resident and confirmed that three people were needed to provide assistance. On , during an interview, Staff K (Caregiver) stated that Resident #17 frequently, which she believed was due to the resident's age. She stated that, to her knowledge, the resident had not broken any , and rescue had responded on several occasions. The review of the health assessments for Resident #17 (dated on), Resident #20 (dated on), Resident #38 (dated on), and Resident #40 (dated on) showed no physical or sensory limitations. A review of the progress notes reveals that On at 11:00 AM, the Resident # 17 was found on the floor, reported and , , while denying hitting her . Fire rescue	{A 165}		

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{A 165}	Continued From page 40 assisted the resident. Later that day, at 4:36 PM, the Resident # 17 returned to the facility from the doctor following evaluation for a from bed and was diagnosed with a T?12-L . A review of the nurse notes reveals that the Resident # 20 was admitted on in stable condition and placed on a 72 hour observation period after a ?related hospital visit. On at 2:30 a.m., she reported left side , from her . A review of the progress notes revealed that on at 9:50 AM, Resident #38 was found on the floor, sitting with her extended, appearing and unable to recall how she . A review of the progress notes reveals that on at 18:05- Resident #40 from wheelchair in apartment, no visible injuries noted, 911 called, refused to go to the hospital. Class III	{A 165}		
{AN278} SS=D	59A-36.022(3) FAC; 429.07(3)(c)2, FS LNS - Records 59A-36.022 (3) RECORDS. (a) A record of all residents receiving limited nursing services and the type of services provided must be maintained at the facility. (b) Nursing progress notes must be maintained for each resident who receives limited nursing services from facility staff. (c) A nursing assessment conducted at least monthly must be maintained on each resident who receives a limited nursing service.	{AN278}		

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{AN278}	Continued From page 41 429.07 (3)(c)2, FS A facility that is licensed to provide limited nursing services shall maintain a written progress report on each person who receives such nursing services from the facility's staff. The report must describe the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health... This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to conduct at least a monthly nursing assessment for a resident who receives limited nursing service (Resident # 16). Findings included: On at 7:28 AM Staff KK [Licensed Practical Nurse] stated that there was only one resident receiving limited nursing services, Resident # 16. A review of Resident # 16's health assessment completed on showed that the resident was diagnosed with advance age and functional decline, , history of , sleep and history of . A review of the limited nursing services (LNS) binder showed that Resident # 16 was under LNS due to a small obstruction secondary to and had a . The last monthly nursing assessment documented was .	{AN278}		

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{AN278}	Continued From page 42 On at 1:24 PM, the Director of Resident Care stated, "are you talking about this nursing assessment?" showing the nursing assessment dated . Class III	{AN278}		