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
	AL11969174	A. BUILDING: _____ B. WING _____	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW ERA COMMUNITY HEALTH CENTER LLC	1351 N KROME AVE HOMESTEAD, FL 33030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation #2026003597 was conducted at New Era Community Health Center on . Deficiencies were identified at the time of the 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 resident diets in accordance with Rule	A 025		

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A 025	Continued From page 1 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 observation, interview and record review the facility failed to maintain a general awareness of resident's whereabouts and failed to ensure that it provided adequate supervision that ensured the health, safety and physical and/or mental wellbeing for three out of 60 sampled residents (Resident #21, Resident #38 and Resident #40). Resident #21 and Resident #38 left the facility with their whereabouts unknown for several hours, during which Resident #38's absence interrupted access to required medication assistance. Resident #40, who required supervision with his activities of daily living, sustained a after staff failed to provide the supervision necessary for his care.	A 025		

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A 025	Continued From page 2 Findings include: During an interview on at 9:30 AM with the Owner, he was asked to recall the events of the day in which Resident #21 and Resident #38 had eloped. The Owner stated that he gave Resident #21 and Resident #38 permission to leave on at 9 PM, he further confirmed that the resident's left through the fence at around 9:30 PM on . When asked how he knew that the residents left, he stated it was because he saw them after staff informed him. The Owner further stated that Resident #38's niece called him the next day, at around noon to inform him of the resident's whereabouts. When asked why the police were called, he stated because he had lost communication with them. When asked if he was concerned about the residents' wellbeing, he stated of course. During an interview on at 8:43 AM with the Owner stated that they [The facility] knew Resident #21 and Resident #38 had left at around 9:30 PM, but the police were still called. When asked if the situation was an elopement, he denied and stated, "because he [Resident #21] was with his brother." When asked why the police were called, he stated because Resident #21 left without them knowing. The Owner later stated that the police were initially called to investigate, but he was aware that the resident went to the Social Security office the next morning; he stated that the office called him the next day, so he believed it was not an elopement. A review of Resident #38's progress note dated revealed that the facility documented "Due to the resident's unexpected absence, the	A 025		

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A 025	Continued From page 3 facility owner contacted law enforcement to report the situation" at 10:00 AM. Four hours later at 2:00 PM, the facility documented that they received a call from the Social Security office " ... notifying me that the resident was physically present there ...". A review of the elopement policy and procedures revealed that it stated " ... if whereabouts are not determined they will be responsible for notifying law enforcement." A review of Resident #38's health assessment dated revealed that had diagnoses of " , , legally due to ( ), (OA), , insufficiency, General , and gait ". He was not identified as an elopement risk and he was independent with ambulation, eating, toileting and transferring, required supervision with bathing and and required assistance with self-administration of medication and required home health care for , injections. 2). An observation on at 4:45 AM revealed that Resident #40 had in attempt to put on his clothing. Further observation revealed that Staff L (Caregiver/Housekeeper) exited from the resident's bathroom to assist the resident with the help of the Owner. During an interview on at approximately 4:45 AM with the Owner, he was asked who will assess the resident, stated "her" [Staff L]. He stated that they would take him to the hospital if they had to. When asked who they	A 025		

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A 025	Continued From page 4 had on staff to assist Resident #40, the Owner stated no one. He further stated that "As Owner and Administrator we see him all day, we assess him. We don't like to wait; we send them to the hospital because we are not qualified to assist." During an interview on at 4:55 AM with Staff L, she was asked what she was doing when Resident #40 , to which she stated that she was changing his bedding. A review of Resident #40's health assessment dated revealed that he required supervision with . Class II	A 025		
A 031 SS=D	59A-36.007(6) FAC Resident Care - Third Party Services (6) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, , and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the	A 031		

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A 031	Continued From page 5 receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the , resident's needs. (c) The administrator or designee must ensure that: 1. Care coordination includes documented communications about the resident's condition and response to treatment or services ordered by the physician which may impact the resident's appropriateness for continued residency in the facility; 2. Communications occur at least once every 30 days and whenever there is a significant change in the resident's condition; and 3. If physician ordered treatments or services occur less often than once a month, communications must be conducted according to the ordered treatment or service schedule and whenever there is a significant change in the resident's condition. 4. When communication with the third party provider is unsuccessful, at least two attempts at communication on two separate days must be documented. Documentation must include the name of the person from the third party provider with whom contact was attempted, the method of communication, and the date and time of the attempts. This documentation must be included in the resident's record in accordance with the timeframes in subparagraphs 59A-36.007(6)(c)2. and 3. (d) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be	A 031		

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A 031	Continued From page 6 received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection. This Statute or Rule is not met as evidenced by: Based on interview and record review the facility failed to maintain an accurate and up to date log of Resident #18 daily / daily documentation. Findings Included: A review of Resident 18's daily / log showed dates , , , and were not documented with level and administration. Interviewed on at 9:47 AM the Owner confirmed that Resident #18 had not left the facility during the dates for which the documentation was missing. The Owner further stated that the agency nurse had been absent on those days and that another nurse had administrated the resident's during that time. Interviewed on at 10:52 AM the Administrator [Home Health] stated the resident had received her as ordered. The Administrator further stated that the regular Registered Nurse had taken several days off and a covering nurse had provided care during that time. The covering nurse did not leave the daily / log at the facility.	A 031		

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A 031	Continued From page 7 Class III	A 031		
A 032 SS=G	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to	A 032		

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A 032	Continued From page 8 admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure that one out of 60 sampled resident (#38) who was at risk of elopement and had identification on their person, left the facility for 3 days and had no identification on his person. Findings included: Observations on at 5:40 AM showed that in the Northeast section of the facility the inner chain-link fence had pieces of plywood	A 032		

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A 032	Continued From page 9 wedge into the bottom of the fence on the outside. During an interview on at 9:30 AM the Owner stated that Resident #38 and Resident #21 left the facility by going under a chain-link fence and jumping the perimeter fence around 9:30 PM on "with permission." The Owner stated that he did not call the police for Resident #38 but only for Resident #21. The Owner stated that residents were free to come and go as they wanted to because the facility respected their rights. A review of Resident #38 progress notes showed that on the resident left the facility with permission and on did not return as expected after attempts to contact the residents were unsuccessful. The note describes that law enforcement was contacted to report the residents as missing. The Resident progress notes dated that on showed that Resident #38 returned to the facility after the niece called them. The progress notes also showed that Resident #38 was giving staff money to buy him goods before and after his disappearance. A review of the facility elopement roster and bracelet check showed that Resident #38 was not on the list. A review of the facility elopement policy and procedures showed that elopement will be determined differently for at risk, not at risk, and for residents on a pass, however on all occasions law enforcement would be notified if the Resident whereabouts were not known. Residents at risk were required to wear an identification bracelet with the facility contact information.	A 032		

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A 032	Continued From page 10 Observation of at 11:20 AM showed that Resident #38 was not wearing an identification bracelet. A review of Resident #38 health assessment dated showed the resident was diagnosed with . The health assessment showed that he was not an elopement risk. The physician indicated that the resident was independent was ambulation, eating, toileting and transferring and needed supervision with bathing and and assistance with self-care. Resident #38 needed assistance with the self-administration of medication and required home health for injections. Class II	A 032		
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	A 052		

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A 052	Continued From page 11	A 052		

from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change.
(c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her .
(d) Applying , medications.
(e) Returning the medication container to proper storage.
(f) Keeping a record of when a resident receives assistance with self-administration under this section.
(g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the .
(4) Assistance with self-administration of medication does not include:
(a) Mixing, , , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed.
(b) The preparation of syringes for injection or the 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 .

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A 052	Continued From page 12 preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. 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	A 052		

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A 052	Continued From page 13 self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and 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	A 052		

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A 052	Continued From page 14 assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure compliance with control procedures when providing assistance with self-administration of medication for 2 out of 60 sampled residents (Resident #17 and 22) and did not note the error, increasing the risk of contamination. The facility also failed to maintain accurate and up-to-date medication assistance waivers for residents receiving medication assistance. Findings Included: 1) Observation on at 5:01 AM revealed Staff G (Medication Technician/ Caregiver) assisted Resident #22 with self-administration of medication. During the process, Staff G dropped four pills onto the medication cart, picked them up, and placed them into the medication cup. The resident then took the medication. Observation on at 5:04 AM showed Staff G assisted Resident #17 with self-administration of medication. During the process, Staff G dropped one pill onto the medication cart, picked it up, and placed them into the medication cup. The resident then took the medication. A review of Staff G's personnel records showed a hire date of and current assistance with self- administration of medication training	A 052		

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A 052	Continued From page 15 dated and control training dated . 2) A review of Resident 17's Medication Observation Records showed that she was taking , delayed release 250 mg tablets and , 20 mg tablets. The written date for both medications was . A review of Resident 17's records revealed an electronic signed waiver, dated , indicating that the resident had elected to opt out of receiving oral notification of the medication name and dosage during assistance with self-administration of medication. The medication and dosage listed; , delayed release 500 mg tablets and , 10 mg tablets. Interviewed on at 12:50 PM the Owner acknowledged that Staff G had not practiced proper control during assistance with self-administration of medication. The Owner also confirmed that the medication waiver had not been updated to reflect the resident's current medication dosages and stated, "okay." Class III	A 052		
A 079 SS=F	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and	A 079		

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A 079	Continued From page 16	A 079		

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 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

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A 079	Continued From page 17 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 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	A 079		

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A 079	Continued From page 18 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 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.	A 079		

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A 079	Continued From page 19 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 observation, interview, and record review, the facility failed to have enough qualified staff to provide resident supervision and to provide or arrange for resident services in accordance with the resident's scheduled and unscheduled service needs. Findings included: Observation on at 4:10 AM found three staff members to care for a census of 129 residents. at 4:40 AM, observation showed Resident # 40 was sitting in his bed in his underwear with his down. Resident # 40 on the floor when he attempted to stand from the bed. Staff were assisting another resident. A review of the staffing schedule for the week of	A 079		

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A 079	Continued From page 20 to showed that three staff members were scheduled to work at the facility from 8:00 PM to 4:30 AM. A review of the residents health assessments regarding the residents who need supervision and assistance with Activities of Daily Living (ADLs) revealed that 114 residents needed supervision with bathing, 106 residents needed supervision with , one resident needed supervision with eating, and one resident needed supervision with grooming, one resident needed assistance with ambulation, four residents needed assistance with bathing, three residents needed assistance with , 128 resident needed assistance with grooming, 14 residents needed assistance with toileting and two residents needed assistance with transferring. Class III	A 079		
A 092 SS=F	59A-36.012(1) FAC Food Service - General Responsibilities (1) GENERAL RESPONSIBILITIES. When food service is provided by the facility, the administrator, or an individual designated in writing by the administrator, must be responsible for total food services and the day-to-day supervision of food services staff. In addition, the following requirements apply: (a) If the designee is an individual who has not completed an approved assisted living facility core training course, such individual must complete the food and nutrition services module of the core training course before assuming responsibility for the facility's food service. The designee is not subject to the 1 hour in-service training in safe food handling practices.	A 092		

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A 092	Continued From page 21 (b) If the designee is a certified food manager, certified dietary manager, registered or licensed dietitian, dietetic registered technician, or health department sanitarian, the designee is exempt from the requirement to complete the food and nutrition services module of the core training course before assuming responsibility for the facility's food service as required in paragraph (1)(a) of this rule. (c) An administrator or designee must perform his or her duties in a safe and sanitary manner. (d) An administrator or designee must provide regular meals that meet the nutritional needs of residents, and therapeutic diets as ordered by the resident's health care provider for residents who require special diets. (e) An administrator or designee must comply with the food service continuing education requirements specified in rule 59A-36.011, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the Administrator performed his or her duties in a safe and sanitary manner for out sampled residents. Findings Included: Observation on at 4:20 AM revealed in the kitchen area a large tray containing multiple packages of ground beef sitting on a kitchen counter. No kitchen staff were present in the area. The ground beef appeared to be thawing, and thawing liquid was observed in the tray beneath the packaged meat. Upon touching the exterior packaging, the meat felt to be at room temperature. Interviewed on at 10:50 AM Staff S	A 092		

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A 092	Continued From page 22 (Cooker) stated that she leaves the meat out overnight to defrost. A review of the facility staffing schedule dated , revealed Staff S was scheduled to work from 7:00 AM to 6:00 PM. A review of Staff S personnel records showed a hire date of and current food handling training dated . Class III	A 092		
A 093 SS=F	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at; https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a	A 093		

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A 093	Continued From page 23 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 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	A 093		

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A 093	Continued From page 24 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. (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:	A 093		

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A 093	Continued From page 25 Based on observation, interview, and record review, the facility failed to follow its menu during lunch. The facility also failed to provide appropriate dinnerware. Findings included: On at 11:30 AM, observation showed the residents were served a cup of juice, fried chickpea, ground beef, two slices of bread, and ice cream. The food was served using disposable plates, cups and utensils. A review of the facility's menu showed that the residents will be served sliced turkey (4 ounces), with gravy, sweet potato (1 cup), green beans (cup), mixed salad (1 cup), salad (1 T), and pudding (cup). On at 12:50 PM, the Administrator stated that they changed the facility's menu done by a dietitian based on residents' preferences. He confirmed that the residents did not receive green beans and mixed salad. He added that they were using disposable tableware and utensils for the residents. Class III	A 093		
A 163 SS=F	429.49 FS Records - Resident, Penalties for Alteration (1) Any person who fraudulently alters, defaces, or falsifies any medical or other record of an assisted living facility, or causes or procures any such offense to be committed, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. (2) A conviction under subsection (1) is also	A 163		

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A 163	Continued From page 26 grounds for restriction, suspension, or termination of license privileges. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the facility records were not falsified. Findings included: On at 11:30 AM, observation showed the residents were served a cup of juice, fried chickpea, ground beef, two slices of bread, and ice cream. On at 11:35 AM, observation showed that a nutritionist's approved residents menu dated was posted in the dining room area. A review of the posted menu revealed lunch menu items consisting of a cup of juice (4 ounces), fried chickpea (1 cup), ground beef (4 ounces), two slices of bread and applesauce (cup). The menu did not show that a diet was offered to the residents. A review of the facility's records showed the nutritionist's approved menu dated showed lunch menu items consisting of sliced turkey (4 ounces), with gravy, sweet potato (1 cup), green beans (cup), mixed salad (1 cup), salad (1 T), and pudding (cup). The menu documented that residents would receive sugar free pudding. On at 12:50 PM, when he was asked why the posted menu items were different from the original nutritionist's menu the Administrator stated that they changed the menu items	A 163		

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A 163	Continued From page 27 according to the resident's preferences and the nutritionist had approved the charges but he did not have documentation for the communication or the nutritionist's approval of the revised menu items. Class II	A 163		
AL243 SS=F	429.075(1) FS; 59A-36.011(9) FAC LMH - Training 429.075 (1) To obtain a limited mental health license, a facility must hold a standard license as an assisted living facility, must not have any current uncorrected violations, and must ensure that, within 6 months after receiving a limited mental health license, the facility administrator and the staff of the facility who are in direct contact with mental health residents must complete training of no less than 6 hours related to their duties. This designation may be made at the time of initial licensure or relicensure or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with this part, part II of chapter 408, and applicable rules. This training must be provided by or approved by the Department of Children and Families. 59A-36.011 (9) LIMITED MENTAL HEALTH TRAINING. (a) Pursuant to section 429.075, F.S., the administrator, managers and staff, who have direct contact with mental health residents in a licensed limited mental health facility, must receive the following training: 1. A minimum of 6 hours of specialized training in working with individuals with mental health	AL243		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
AL243	Continued From page 28 diagnoses. a. The training must be provided or approved by the Department of Children and Families and must be taken within 6 months of the facility's receiving a limited mental health license or within 6 months of employment in a limited mental health facility. b. Training received under this subparagraph may count once for 6 of the 12 hours of continuing education required for administrators and managers pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 2. A minimum of 3 hours of continuing education, which may be provided by the ALF administrator, online, or through distance learning, biennially thereafter in subjects dealing with one or more of the following topics: a. Mental health diagnoses; and, b. Mental health treatment such as: (I) Mental health needs, services, behaviors and appropriate interventions; (II) Resident progress in achieving treatment goals; (III) How to recognize changes in the resident's status or condition that may affect other services received or may require intervention; and, ( ) Crisis services and the procedures. 3. For administrators and managers, the continuing education requirement under this subsection will satisfy 3 of the 12 hours of continuing education required biennially pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 4. Administrators, managers and direct contact staff affected by the continuing education requirement under this subsection shall have up to 6 months after the effective date of this rule to meet the training requirement.	AL243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969174	A. BUILDING: _____ B. WING _____	05/28/2026

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AL243	Continued From page 29 (b) Administrators, managers and staff do not have to repeat the initial training should they change employers provided they present a copy of their training certificate to the current employer for retention in the facility's personnel files. They must also ensure that copies of the continuing education training certificates, pursuant to subparagraph (a)2. of this subsection, are retained in their personnel files. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure the staff who had direct contact with residents with mental health conditions received a minimum of six hours of specialized training in working with individuals with mental health diagnoses for four out of four (Staff C, G, K, and N) sampled staff. Findings included: A review of the facility's license revealed a limited mental health specialty component. A review of Staff C's personal record showed documentation of an initial six-hour training dated , received by an unauthorized trainer. Staff C was hired on . A review of Staff G's personal record showed documentation of an initial six-hour training dated , received by an unauthorized trainer. Staff C was hired on . A review of Staff K's personal record showed documentation of an initial six-hour training dated , received by an unauthorized trainer. Staff C was hired on .	AL243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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AL243	Continued From page 30 A review of Staff N's personal record showed documentation of an initial six-hour training dated , received by an unauthorized trainer. Staff C was hired on . On at 12:50 PM, the Administrator acknowledged that Staff C, Staff G, Staff K and Staff N received initial training of six hours by an unauthorized trainer. Class III	AL243		