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
	AL11911401	A. BUILDING: _____ B. WING _____	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA SERENA VII	3317 SW 24 TERRACE MIAMI, FL 33145

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A re-licensure survey was conducted at Serena VII from through . Deficiencies were identified at the time of the survey.	A 000		
A 010 SS=G	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician	A 010		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

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

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A 010	Continued From page 3 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A _____, ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C.	A 010		

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A 010	Continued From page 4 This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure the appropriateness of continued residency for one out of twelve sampled residents (2). The Resident had a history of aggressive behavior toward other residents and physically assaulted his roommate. Findings included: A review of Resident 2's progress note dated showed," [Resident 2] had documented behavioral incident during . On , the Resident exhibited behavioral difficulties directed toward other facility residents. The incident was reported to administration and was under review pending resolution. An incident report was completed and filed per facility protocols. On , the case manager visited the facility and met with the Resident. No medical , , , medication changes, home health orders, or family visits were documented during this period. All activities of daily living were maintained with appropriate staff assistance. Resident continues under regular monitoring per facility protocols" A review of a progress note form for Resident 2 dated showed "Physical aggression. The Resident assaulted, struck a roommate" Further review showed, "During the month of the Resident presented ongoing behavioral and nutritional challenges. On Resident assaulted and struck a roommate" Further review showed the primary care provider and follow up sections of the progress note form were left blank.	A 010		

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A 010	Continued From page 5 Further review of Resident 2's record showed no documentation for a medical or , intervention regarding Resident 2's aggressive and violent behavior toward other residents. Observation on at 7:12 AM showed that Resident 2 was in bed with a in place with a full drainage bag on the floor. The Resident made a rude dismissive gesture, turned his and refused to be interviewed. Interviewed on at 12:25 PM the Administrator stated that Resident 2 had physically assaulted his roommate. Asked about an evaluation of Resident 2 after the incident and the facility's resolution, the Administrator stated the facility did not keep , records, and he had replaced Resident 2's roommate with another resident. The Administrator stated, "He slapped [Resident 6] when he was passing by. [Resident 2] is , . I decided to change [Resident 6] with [Resident 8]; he is his roommate now. We don't keep , records here" A review of Resident 2's hospital record dated showed a relevant medical history of , , , paranoia, , , , care, , retention, recent and frequent , unspecified obstruction, , gait problems and , . A review of Resident 2's health assessment dated showed diagnoses of history of solid of the , and . Physical limitations showed lower extremity , with bed mobility, minimum assistance without support. The status	A 010		

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A 010	Continued From page 6 showed that the Resident was alert and oriented to time, place, self and situation. Nursing requirements showed home health services for ˬ care, ˬ ˬ , , , and home health. The activities of daily living (ADL) showed the Resident needed assistance with ambulation, bathing, ˬ, self-care, eating and toileting and needed supervision with transferring. The Resident needed assistance with self-administration of medication. Interviewed on at 12:20 PM the Home Health Nurse stated Resident 2 received nursing visits twice per week for ˬ care. She stated, "We trained the [facility] staff; they empty his ˬ bag" Class II	A 010		
A 025 SS=E	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 ˬ , 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	A 025		

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A 025	Continued From page 7 is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, 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	A 025		

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A 025	Continued From page 8 failed to provide supervision according to the needs of one out of twelve sampled residents (1) The facility also failed to obtain a physician's evaluation for two out of twelve sampled residents that exhibited a significant change in condition (1, 2) Resident 1 eloped from the facility and was found by police in the streets. Resident 2 exhibited aggressive behavior patterns toward other residents and assaulted his roommate. Findings included: Resident 1) Interviewed on at 7:05 AM Staff B stated that Resident 1 had recently eloped, he was found by police and brought to the facility. "It was about two weeks ago. He got out, got on a trolley and got lost. The police found him" Interviewed on at 8:26 AM, the Administrator stated that Resident 1 had eloped when a side door was left open and the Resident got lost. The Administrator further stated that the police were notified, found the Resident in the streets and brought him to the facility. A review of Resident 1's progress notes dated showed the Resident was found missing at 7:00 PM during a medication pass and the police were notified when he could not be found. Further review showed the police returned the Resident to the facility at around 10:00 PM after they found him in the streets; further review showed emergency medical services ( ) was activated because the Resident was shaking. A review of Resident 1's record revealed an undated progress note showing," During , [Resident 1] remained generally stable with	A 025		

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A 025	Continued From page 9 staff noting a characteristic tendency toward easy disorientation requiring supervision. Psychiatrist evaluated the Resident" Interviewed on at 11:20 AM Resident 1 stated he did not know where he lived or the address or telephone number for the facility. When asked which city he lived in Resident 1 stated, "In a hospital" A review of Resident 1's most recent health assessment dated showed diagnoses of , Type 2 , high , , and history of . Physical limitations showed unsteady gait. status showed diminished memory and concentration. Nursing requirements showed , , , / , , as needed. Special precautions showed universal precautions. The Resident was not an elopement risk. The activities of daily living showed the Resident needed supervision with ambulation, bathing, , toileting and transferring, and was independent with eating. The Resident needed assistance with self-administration of medications. Further review of Resident 1's record showed no documentation for notification to or an evaluation by the Resident's health care provider after his elopement incident on . Interviewed on at 12:25 PM when it was noted that Resident 1's health assessment indicated he was not at risk for elopement and he was asked about a physician's evaluation of the Resident after the elopement incident the Administrator stated he updated the resident records once a month and the Resident's record had not been updated yet.	A 025		

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A 025	Continued From page 10 Resident 2) A review of Resident 2's progress note dated showed that Resident 2 had documented behavioral incident during and that on , the Resident exhibited behavioral difficulties directed toward other facility residents. Further review showed, "No medical , medication changes, home health orders, or family visits were documented during this period" A review of Resident 2's progress note dated showed that Resident 2 physically assaulted and struck his roommate. Further reviews showed, "During the month of the Resident presented ongoing behavioral and nutritional challenges. On Resident assaulted and struck a roommate" Further reviews showed the progress note sections for primary care and the follow-up care were left blank. Further review of Resident 2's record showed no documentation for a medical or a evaluation following the Resident's pattern of aggressive and violent behavior. Interviewed on at 12:25 PM the Administrator stated that Resident 2 had physically assaulted his roommate. When he was asked why Resident 2 was not evaluated the Administrator stated that records were not kept at the facility. The Administrator stated, "We don't keep records here" Class III	A 025		

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A 027	Continued From page 11	A 027		
A 027 SS=E	59A-36.007(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making , , and remind residents about scheduled , , for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation. (c) The facility may not require residents to receive services from a , health care provider. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to arrange medical services for one out of twelve sampled residents (2) after the Resident was discharged from the hospital with orders for follow up care with the primary care provider for acute , . Findings included: A review of Resident 2's hospital record dated showed the Resident was treated in the emergency department for acute , and had discharge orders for follow up care with the primary care physician within one or two days. A review of Resident 2's most recent health assessment dated showed diagnoses of history of solid , of the ,	A 027		

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A 027	Continued From page 12 and Physical limitations showed lower extremity with bed mobility, minimum assistance without support. The status showed that the Resident was alert and oriented to time, place, self and situation. Nursing requirements showed home health services for care, and home health. The activities of daily living (ADL) showed the Resident needed assistance with ambulation, bathing, self-care, eating and toileting and needed supervision with transferring. The Resident needed assistance with self-administration of medication. Further review of Resident 2's record showed no documentation for follow-up care with the primary care physician after he was discharged from the hospital. Interviewed on AT 1:00 PM when noted that there was no documentation for Resident 2's evaluation after he was discharged from the hospital the Administrator stated he updated the resident's notes monthly and not all records were updated. Class III	A 027		
A 032 SS=D	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	A 032		

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A 032	Continued From page 13 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 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	A 032		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 032	Continued From page 14 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 observation, record review and interview, the facility failed to follow its own elopement procedures for one out of twelve sampled residents (1). The Resident had , was disoriented and was found in the streets by police after he eloped from the facility. Findings included: Interviewed on at 11:20 AM Resident 1 stated he did not know where he lived or the address or telephone number of the facility. When asked which city he lived in Resident 1 stated, "In a hospital" Interviewed on /202 at 8:26 AM, the Administrator stated that Resident 1 had eloped when a side door was left open and the Resident got lost. The Administrator further stated the police were notified, found the Resident in the streets and brought him to the facility. A review of Resident 1's progress notes dated	A 032		

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	AL11911401	A. BUILDING: _____ B. WING _____	06/16/2026

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A 032	Continued From page 15 showed the Resident was found missing at 7:00 PM during medication pass and when he could not be found the police were notified. Further review showed the police returned the Resident to the facility at around 10:00 PM after they found him in the streets. Further review revealed (Emergency Medical Service) was activated because the Resident was shaking. A review of Resident 1's most recent health assessment dated showed diagnoses of , the status showed diminished memory and concentration. Physical limitations showed unsteady gait and the activities of daily living showed the Resident needed supervision with ambulation, bathing, , toileting and transferring, and assistance with self-administration of medications. Not an elopement risk. Universal precautions were indicated. A review of Resident 1's record revealed an undated progress note showing," During [Resident 1] remained generally stable with staff noting a characteristic tendency toward easy disorientation requiring supervision. Psychiatrist evaluated the Resident" Further review of Resident 1's record showed the most recent elopement risk evaluation was dated . A review of the facility's elopement policy showed: " Procedure- 3. All residents will be assessed for elopement within 72 hours of admission and periodically if a significant change occurs." "4. C. Special attention will be given to patients determined to be at high risk or who suffer from	A 032		

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A 032	Continued From page 16 and related " Class III	A 032		
A 036 SS=D	59A-36.007(10) CONTROL PROCEDURES (10) CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of . (a) The facility must implement a hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or , hygiene may include the use of -based rubs, , handwash, or handwashing with soap and water. (b) Standard precautions must be used when there is an , exposure to transmissible agents in , , , nonintact skin, and mucuous during the provision of personal services. Standard precautions include: hygiene, and dependent upon the exposure, use of gloves, gown, mask, , protection, or a shield. (c) The facility must clean and reusable medical equipment and communal assistive devices that have been designed for use by multiple residents before and after each use according to the manufacturer's recommendations. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to provide services in a manner that reduced the risk of transmission of for one out of twelve sampled	A 036		

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A 036	Continued From page 17 residents (2) Resident 2 had an unsecured bag full of on the floor. Findings included: Observation on at 7:12 AM showed that Resident 2 was in bed in with a in place. Further observations showed the drainage bag was not attached, it was full and was laying on the floor next to the Resident's bed. Further observation showed Resident 1's roommate was in the room. Observation on at 11:45 AM showed Resident 2 was asleep in # and his drainage bag was full, unattached and lying on the floor. Interviewed on at 11:47 AM-Caregiver D stated" He always throws it [the bag] on the floor. He drags it around all over the place" According to the CDC (Center for Control), " drainage bags must be kept off the floor and must be emptied prior to transport" Class III	A 036		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription	A 054		

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A 054	Continued From page 18 number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to have an accurate and up to date medication observation record for one out of twelve sampled residents (4) Medications that were not applied to the Resident were signed as given on the medication observation record (MOR) Findings included: Observation on at 7:50 AM showed	A 054		

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A 054	Continued From page 19 that Staff C assisted Resident 4 with self-administration of medication. Further observation revealed the medications solution , , , 12% lotion and A and D preventive that were ordered daily at 8:00 AM were not applied to the Resident. A review of Resident 4's medication observation record (MOR) showed the medications solution , , , 12% lotion and A and D preventive dosages for at 8:00 AM were signed as given to the Resident. Interviewed on at 8:05 AM when asked why the medications were signed on the MOR when she did not give the medications to the Resident Staff C stated, "I forgot. I will give [medications] to him now" Class III	A 054		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the	A 056		

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A 056	Continued From page 20 container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or	A 056		

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A 056	Continued From page 21 electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to follow the prescribing health care provider's orders for one out of twelve sampled residents (4) Medications were not given to the Resident as ordered. Findings included:	A 056		

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A 056	Continued From page 22 A review of Resident 4's medication records showed the medications solution , , , 12% lotion and D preventive were ordered daily at 8:00 AM. Observation on at 7:50 AM showed that Staff C assisted Resident 4 with self-administration of medication and did not apply the medications solution , , , 12% lotion and A and D preventive to the Resident. Interviewed on at 8:05 AM when asked why the medications were signed on the MOR when she did not give the medications to the Resident Staff C stated, "I will give [medications] to him now" Class III	A 056		
A 152 SS=F	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings:	A 152		

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A 152	Continued From page 23 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable ˘ to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe living environment, free of hazards for twelve out of twelve sampled residents. Findings included: Observations on and on from 7:00 AM through 12:00 PM revealed: A large stain on the wall next to the resident's bed in # where Resident 10 and Resident 9 lived. Three large unsecured (without retention chain or base) metal gas tanks on the terrace near a	A 152		

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A 152	Continued From page 24 resident seating area. Construction materials, broken wood pallets, loose 2 x 4 boards and a loose water hose on the patio floor that presented a hazard. A review of the facility's profile revealed a specialty license for limited mental health services (LMH) The terrace and patio were unrestricted common use areas and residents were observed walking and sitting around while maintenance staff were working. (Photographic evidence obtained) Class III	A 152		
A 160 SS=E	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from	A 160		

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A 160	Continued From page 25 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 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.	A 160		

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A 160	Continued From page 26 (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.; (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.	A 160		

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A 160	Continued From page 27 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain an accurate admission and discharge log for two out of twelve sampled residents (5, 1) Findings included: Observation on at 7:14 AM revealed that Resident 5 was in his room. A review of the facility admission and discharge log revealed that Resident 5 was not listed. Interviewed on at 7:45 AM when it was noted that Resident 5 was not listed on the admission and discharge log the Assistant Administrator stated she did not know and she would find out. Further review of the admission and discharge log revealed Resident 1 was identified as limited mental health (LMH). Interviewed on at 8:00 AM the Administrator stated Resident 1 was listed as LMH by mistake because his condition did not qualify him for LMH (Limited mental health services). The Administrator stated," It must be a mistake of the previous administrator. [Resident 1] doesn't qualify for LMH. doesn't qualify" Class III	A 160		
A 161 SS=D	429.275(2) FS; 59A-36.015(2) FAC Records - Staff	A 161		

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A 161	Continued From page 28 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by Rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section 429.174, F.S., and Rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C.	A 161		

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	AL11911401	A. BUILDING: _____ B. WING _____	06/16/2026

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A 161	Continued From page 29 (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity _____, to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by Rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to maintain employee personnel records and the written work schedule of one out of six sample employees (C) Findings included: Observation on at 7:00 AM revealed that Staff C was on duty at the facility. A review of the facility's staffing pattern schedule showed that Staff C was not listed. Interviewed on at 7:10 AM Staff C stated she was covering for another employee but did not have any employment records and she provided a Florida Driver's license for identification. Interviewed on at 7:12 AM Staff B stated she could not provide employment records for Staff C. Interviewed on at 7:45 AM, the	A 161		

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A 161	Continued From page 30 Assistant Administrator stated that she would try to obtain Staff C's employment records Interviewed on at 8:00 AM when it was noted that Staff C was not listed on the facility's staffing schedule and her employment records were not available, the Administrator stated that Staff C was employed at another facility, and he would obtain copies of her employment records. Class III	A 161		
A 162 SS=E	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or	A 162		

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A 162	Continued From page 31 other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A ␣ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their ␣ recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that ␣ not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging	A 162		

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A 162	Continued From page 32 to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No =Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period	A 162		

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A 162	Continued From page 33 of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain updated health assessments for two out of twelve sampled residents (1, 2) following significant changes in condition. Findings included: Resident 1) Interviewed on /202 at 8:26 AM, the Administrator stated that Resident 1 had eloped and got lost. The Administrator further stated that the police found the Resident in the streets and brought him to the facility. A review of Resident 1's progress notes dated showed the Resident was found missing at 7:00 PM during medication pass and when he could not be found the police were notified. Further review showed the police returned the Resident to the facility at around 10:00 PM after they found him in the streets. Further review revealed was activated because the Resident was shaking. A review of Resident 1's most recent health assessment dated showed diagnoses of , Type 2 , high , , and history of . Further review of Resident 1's record showed the	A 162		

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A 162	Continued From page 34 Resident was not at risk for elopement. Resident 2) A review of Resident 2's hospital record dated revealed the Resident was diagnosed with retention, recent and frequent , unspecified obstruction, , paranoia, and . A review of Resident 2's hospital record dated showed the Resident was diagnosed with acute . A review of Resident 2's most recent health assessment dated showed diagnoses of history of solid of the , and . Further review of Resident 2's record showed no documentation for an updated health assessment after the Resident was hospitalized with acute retention and . Interviewed on at 1:00 PM when noted that there was no documentation for Resident 1 and Resident 2's updated heath assessments the Administrator stated he updated the resident's notes monthly and not all records had been updated yet. Class III	A 162		
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	A 165		

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A 165	Continued From page 35 part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more 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	A 165		

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A 165	Continued From page 36 incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and 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	A 165		

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A 165	Continued From page 37 are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to report an adverse incident on the Agency portal after placing a service call to the police due to a resident elopement. Findings included: Interviewed on at 7:05 AM Staff B stated that Resident 1 had recently eloped, was found by police and brought to the facility. "It was about two weeks ago. He got out, got on a trolley and got lost. The police found him" Interviewed on at 8:26 AM, the Administrator stated that Resident 1 had eloped when a side door was left open and the Resident got lost. The Administrator further stated that the police were notified, found the Resident in the streets and brought him to the facility. A review of Resident 1's progress notes dated .. showed the Resident was found missing at 7:00 PM during medication pass and the police were notified. Further review showed the police returned the Resident to the facility at around 10:00 PM after they found him in the streets. Further review revealed (Emergency Medical Service) was activated because the Resident was shaking. A review of the facility on AIRS (Adverse Incident	A 165		

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A 165	Continued From page 38 Reporting System) showed the elopement incident was not reported. Interviewed on /202 at 8:26 AM when it was noted that Resident 1's elopement incident had not been reported, the Administrator stated he would file the report. Class III	A 165		
A 200 SS=F	59A-36.025 FAC Emergency Environmental Control 59A-36.025 Emergency Environmental Control for Assisted Living Facilities. (1) DETAILED EMERGENCY ENVIRONMENTAL CONTROL PLAN. Each assisted living facility shall prepare a detailed plan ("plan") to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency environmental control in the event of the loss of primary electrical power in that assisted living facility which includes the following information: (a) The acquisition of a sufficient alternate power source such as a generator(s), maintained at the assisted living facility, to ensure that current licensees of assisted living facilities will be equipped to ensure air temperatures will be maintained at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. 1. The required temperature must be maintained in an area or areas, determined by the assisted living facility, of sufficient size to maintain residents safely at all times and that is appropriate for resident care needs and life safety requirements. For planning purposes, no less than twenty (20) net square per resident must be provided. The assisted living facility may	A 200		

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A 200	Continued From page 39 use eighty percent (80%) of its licensed bed capacity as the number of residents to be used in the to determine the required square footage. This may include areas that are less than the entire assisted living facility if the assisted living facility's comprehensive emergency management plan includes allowing a resident to congregate when he or she desires in portions of the building where temperatures will be maintained and includes procedures for monitoring residents for signs of heat related injury as required by this rule. This rule does not prohibit a facility from acting as a receiving provider for evacuees when the conditions stated in Section 408.821, F.S. and subsection 59A-36.019(5), F.A.C., are met. The plan shall include information regarding the area(s) within the assisted living facility where the required temperature will be maintained. 2. The alternate power source and fuel supply shall be located in an area(s) in accordance with local zoning and the Florida Building Code. 3. Each assisted living facility is unique in size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and staffing characteristics. Accordingly, this rule does not limit the types of systems or equipment that may be used to achieve temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. The plan shall include information regarding the systems and equipment that will be used by the assisted living facility and the fuel required to operate the systems and equipment. a. An assisted living facility in an evacuation zone pursuant to Chapter 252, F, S. must maintain an alternative power source and fuel as required by	A 200		

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A 200	Continued From page 40 this subsection at all times when the assisted living facility is occupied but is permitted to utilize a mobile generator(s) to enable portability if evacuation is necessary. b. Assisted living facilities located on a single campus with other facilities under common ownership, may share fuel, alternative power resources, and resident space available on the campus if such resources are sufficient to support the requirements of each facility's residents, as specified in this rule. Details regarding how resources will be shared and any necessary movement of residents must be clearly described in the emergency power plan. c. A multistory facility, whose comprehensive emergency management plan is to move residents to a higher floor during a flood or surge event, must place its alternative power source and all necessary additional equipment so it can safely operate in a location protected from flooding or storm surge damage. (b) The acquisition of sufficient fuel, and safe maintenance of that fuel at the facility, to ensure that in the event of the loss of primary electrical power there is sufficient fuel available for the alternate power source to maintain temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours after the loss of primary electrical power during a declared state of emergency. The plan must include information regarding fuel source and fuel storage. 1. Facilities must store minimum amounts of fuel onsite as follows: a. A facility with a licensed capacity of 16 beds or less must store 48 hours of fuel onsite. b. A facility with a licensed capacity of 17 or more beds must store 72 hours of fuel onsite. 2. An assisted living facility located in an area in a	A 200		

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A 200	Continued From page 41 declared state of emergency area pursuant to Section 252.36, F.S. that may impact primary power delivery must secure ninety-six (96) hours of fuel. The assisted living facility may utilize portable fuel storage containers for the remaining fuel necessary for ninety-six (96) hours during the period of a declared state of emergency. 3. Piped natural gas is an allowable fuel source and meets the onsite fuel supply requirements under this rule. 4. If local ordinances or other regulations limit the amount of onsite fuel storage for the assisted living facility's location, then the assisted living facility must develop a plan that includes maximum onsite fuel storage allowable by the ordinance or regulation and a reliable method to obtain the maximum additional fuel at least 24 hours prior to depletion of onsite fuel. (c) The acquisition of services necessary to maintain, and test the equipment and its functions to ensure the safe and sufficient operation of the alternate power source maintained at the assisted living facility. (d) The acquisition and maintenance of a monoxide alarm. (2) SUBMISSION OF THE PLAN. (a) Each new assisted living facility shall submit the plan required under this rule prior to obtaining a license. (b) Each existing assisted living facility that undergoes any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of its systems or equipment affecting the facility's compliance with this rule shall amend its plan and submit it to the county emergency management agency for review and approval. (3) APPROVED PLANS. (a) Each assisted living facility must maintain a	A 200		

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A 200	Continued From page 42 copy of its approved plan in a manner that makes the plan readily available at the licensee's physical address for review by a legally authorized entity. If the plan is maintained in an electronic format, assisted living facility staff must be readily available to access and produce the plan. For purposes of this section, "readily available" means the ability to immediately produce the plan, either in electronic or paper format, upon request. (b) Within 30 days of the approval of the plan from the county emergency management agency, the assisted living facility shall submit in writing proof of the approval to the Agency for Health Care Administration to assistedliving@ahca.myflorida.com. (c) The assisted living facility shall submit a consumer-friendly summary of the emergency power plan to the Agency. The Agency shall post the summary and notice of the approval and implementation of the assisted living facility emergency power plans on its website within ten (10) business days of the plan's approval by the county emergency management agency and update within ten (10) business days of implementation. (4) IMPLEMENTATION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall, no later than . , have implemented the plan required under this rule. (b) Each new assisted living facility shall implement the plan required under this rule prior to obtaining a license. (c) Existing assisted living facilities that undergo any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of the systems or equipment affecting the assisted living facility's compliance	A 200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911401	A. BUILDING: _____ B. WING _____	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA SERENA VII	3317 SW 24 TERRACE MIAMI, FL 33145

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A 200	Continued From page 43	A 200		

with this rule shall implement its amended plan concurrent with any such additions, modifications, alterations, refurbishment, renovations or reconstruction.
(5) POLICIES AND PROCEDURES.
(a) Each assisted living facility shall develop and implement written policies and procedures to ensure that the assisted living facility can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. The procedures shall ensure that residents do not experience complications from fluctuations in air temperatures inside the facility. Procedures must address the care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury including:
1. The use of cooling devices and equipment;
2. The use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration;
3. Wellness checks by assisted living facility staff to monitor for signs of , and heat injury; and
4. A provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy.
(b) Each assisted living facility shall maintain the written policies and procedures in a manner that makes them readily available at the licensee's physical address for review by a legally authorized entity. If the policies and procedures are maintained in an electronic format, assisted living facility staff must be readily available to access the policies and procedures and produce the requested information. For purposes of this section, "readily available" means the ability to

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	AL11911401	A. BUILDING: _____ B. WING _____	06/16/2026

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A 200	Continued From page 44 immediately produce the policies and procedures, either in electronic or paper format, upon request. (c) The written policies and procedures must be readily available for inspection by each resident; each resident's legal representative, designee, surrogate, guardian, attorney in fact, or case manager; each resident's estate; and such additional parties as authorized in writing or by law. (6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this rule, the Agency for Health Care Administration may seek any remedy authorized by Chapter 429, Part I, or Chapter 408, Part II, F.S., including, but not limited to, license revocation, license suspension, and the imposition of administrative fines. (7) COMPREHENSIVE EMERGENCY MANAGEMENT PLAN. (a) Assisted living facilities whose comprehensive emergency management plan is to evacuate must comply with this rule. (b) Each facility whose plan has been approved shall submit the plan as an addendum with any future submissions for approval of its comprehensive emergency management plan. (8) NOTIFICATION. (a) Within five (5) business days, each assisted living facility must notify in writing, unless permission for electronic communication has been granted, each resident and the resident's legal representative: 1. Upon the initial submission of the plan to the county emergency management agency that the plan has been submitted for review and approval; 2. Upon final implementation of the plan by the assisted living facility. 3. Annual submissions and approvals of the plan do not require notification to residents or their	A 200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 200	Continued From page 45 legal representatives unless a significant modification as defined in Rule 59A-36.019, F.A.C., has been made to the plan. (b) Each assisted living facility must maintain a copy of each notification set forth in paragraph (a) above in a manner that makes each notification readily available at the licensee's physical address for review by a legally authorized entity. If the notifications are maintained in an electronic format, facility staff must be readily available to access and produce the notifications. For purposes of this section, "readily available" means the ability to immediately produce the notifications, either in electronic or paper format, upon request. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to have a working emergency power generator that could be activated in case of the loss of primary power. The generator could not be started. Findings included: Observation on at 7:40 AM showed that Staff C pulled out a portable emergency power generator (Duro Max Dual Fuel XP13000) from a patio shed, connected it to a small propane tank with a hose and attempted to test-start the generator for several minutes and the generator would not start. The generator never started. Interviewed on at 7:55 AM Staff C stated, "I know how to start it. I don't know why it doesn't start" Class III	A 200		