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
	AL11968520	A. BUILDING: _____ B. WING _____	06/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE AT CORAL GABLES, THE	1 ANDALUSIA AVE CORAL GABLES, FL 33134

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

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A 025	Continued From page 1 (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 provide adequate supervision according to the residents' needs and failed to maintain a written updated record as needed. This affected 1 of 15 sampled residents (Resident #1). Findings include: On at 8:40 AM, during an interview, Resident #1 complained that she did not remember how long it took facility staff to find her after she passed out during an incident prior to the survey. On at 9:15 AM, Resident #1 had been	A 025		

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A 025	Continued From page 2 observed outside her room ambulating with a walker without supervision. On at 9:15 AM, During the interview, Resident #1 stated that she had while using her walker. She reported that she was unable to apply the brakes properly, which resulted in a , . She added that she was transported to the hospital. On at 2:00 PM, during an interview, the Administrator stated that Resident #1 had not suffered a , . A review of Resident #1's file revealed that there was no hospital discharge note regarding the that occurred on . A further review of the [Hospital] records reveals that Resident #1 was attended on due to a , . Class III	A 025		
A 036 SS=E	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	A 036		

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A 036	Continued From page 3 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 ensure that services were provided in a manner that minimized the risk of transmission of . Affecting 2 of our 15 sampled residents (Resident # 1 and Resident # 8). Findings Include: On at 9:25 AM, observation showed that Staff P (Certified Nursing Assistant), after using sanitizer, touched the laptop, medication cart, and her hair before preparing medication for Resident #1. Throughout this process, she did not use gloves. On at 10:30 AM, Staff S (Certified Nursing Assistant), after using sanitizer, was observed touching the laptop and medication cart before preparing medication for Resident #8 in a cup. Additionally, after throwing the cup into the trash, she touched the trash can and then touched the laptop and medication cart again. During this procedure, she did not use gloves.	A 036		

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A 036	Continued From page 4 On at 6:38 AM, Staff F (Registered Nurse) stated that certified nursing assistants (CNAs) had been trained to pass medications as long as they were able to read the order. A review of the facility's control policies revealed insufficient information to ensure accurate guidance for preventing the spread of . Class III	A 036		
A 052 SS=E	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the	A 052		

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A 052	Continued From page 5 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 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	A 052		

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A 052	Continued From page 6 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 [illegible] or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take	A 052		

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A 052	Continued From page 7 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 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:	A 052		

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A 052	Continued From page 8 Based on observation and interview the facility failed to provide assistance with self administration of medications from the original labeled container, affecting 1 of our 15 sampled residents. (Resident # 15). Findings include: On at 6:15 AM, a prepared cup containing pills with the room number written on top was observed on the nursing station counter. Staff J (Certified Nursing Assistant) and Staff R (Certified Nursing Assistant) were present. Photographic evidence was obtained. On at 6:38 AM, during the interview Staff N (Registered Nurse) stated that Staff J and Staff R were allowed to pass medications and wrote room numbers on the cups. She said she didn't know the protocol but that staff were trained to pass meds if they could read the order. Class III	A 052		
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,	A 056		

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A 056	Continued From page 9 2. The identification of each medicinal drug in the 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	A 056		

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A 056	Continued From page 10 provider within 10 working days. A faxed or 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, interview, and record review, the facility failed to ensure the health care provider was contacted and requested to provide revised instructions for an "as needed" prescription. Resident #1 did not have a doctor's order for an "as needed" prescription or revised	A 056		

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A 056	Continued From page 11 instructions. Findings include: Observation on at 9:25 AM revealed Staff P (Certified Nursing Assistant) prepared medication for Resident #1, but Resident #1 was sleeping. Staff P stated the medication was scheduled to be given between 7:00 AM and 11:00 AM, so she would return later to assist Resident #1. A review of Resident #1's MOR (Medication Observation Record) revealed , , 500 milligrams, tablet, oral. 2 tablets (1000 milligrams) by every 12 hours as needed. A review of Resident #1 file revealed Resident #1's health provider did not have revised instructions for an "as needed" prescription. During an interview on at 12:23 PM, Staff B (Chief of Nursing Office) stated "you can take , if you're alert and oriented times 4 then use judgement ... I'm going to look that up." When informed about as needed prescription that lacked a health care provider order and special instructions. Class III	A 056		
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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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 13 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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PALACE AT CORAL GABLES, THE	1 ANDALUSIA AVE CORAL GABLES, FL 33134

(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 079	Continued From page 14 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 15 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, record review, and interview, the facility failed to ensure sufficient and adequate staffing was available to meet the schedule and unscheduled residents. The facility only had three employees (Staff F, G, H, J, and R) assigned to care for 80 residents overnight. Findings include: A review of the staffing hours report dated from 11:00 PM - 7:00 AM showed Staff F (Registered Nurse), J, and R (Certified Nursing Assistant) were on schedule. A review of the Nursing staff hours report dated from 11:00 PM - 7:00 AM showed Staff G (Licensed Practical Nurse), H, and J (Certified Nursing Assistant) were on schedule. Observation on at 6:15 AM revealed	A 079		

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A 079	Continued From page 16 only two direct care employees Staff J and Staff R were at the nursing station on the third floor. During an interview on at 6:15 AM both Staff J and Staff R were asked about the resident census. Staff J and Staff R stated they did not know how many residents lived in the building or how many spoke only English. During an interview on at 6:25 AM Staff F stated, "I believe it's 120." When asked what the building census was. Staff F voiced, "I can't give you that exact number" when asked how many residents were in assisted living. Staff F expressed, "about 4 that's in assisted living to be exact" when asked how many residents were on hospice. Staff F stated, "it's only two CNAs on duty and no one else, it's 3 of us that cover the residents." Class III	A 079		
A 093 SS=I	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_	A 093		

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A 093	Continued From page 17 Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of 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	A 093		

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A 093	Continued From page 18	A 093		

served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months.
(e) Therapeutic diets must be prepared and served as ordered by the health care provider.
1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility.
2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal.
(f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals.
(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

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A 093	Continued From page 19 at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure a 3-day supply of nonperishable food, always be on at all times. Findings include: Observation on at 10:42 AM revealed no emergency food in kitchen pantry. During an interview on at 10:44 AM, Staff O (Chef) stated "this is what we do every year we order with (foodservice distributor) when we're preparing for emergencies." When asked where the emergency food was, Staff O stated, "no we don't have it physically, but I'll submit the order and we'll have it." During an interview on at 12:12 PM the Administrator stated "okay" when informed about the lack of emergency food supply. Class II	A 093		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must:	A 152		

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A 152	Continued From page 20 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: 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 ensure that all existing architectural, mechanical, electrical and structural systems,	A 152		

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A 152	Continued From page 21 and appurtenances were maintained in good working order. The facility failed to be free from assistive device that's included a total body lift or a motorized sit-to stands lift that a resident can't operate independently. For one out of 15 sample residents. (Resident #3). Findings included: During the facility tour on at 6:55 A.M., observed a full length floor to ceiling structural crack on the wall adjacent to the kitchen entry. (photo was taken). Further observation at 7:08 A.M., a was found in Resident #3's bathroom. During a preliminary exit on At 12:23 P.M., the administrator stated that the is the Resident #3 personal property. He explained that Resident #3 had the lift for years and she is trying to sell it. Furthermore, administrator stated I cannot remove the lift from the facility because it belongs to the resident. During a phone exit interview on at 2:00 P.M., administrator stated," you said that it is cracked on the wall, but this is new building." Class III	A 152		
A 162 SS=B	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,	A 162		

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A 162	Continued From page 22 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 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	A 162		

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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 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

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A 162	Continued From page 24 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 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 interview and record review, the facility failed to have a new health assessment for one out of 15 sampled residents. Resident #1 was sent to the hospital with , ... The facility failed to obtain or maintain hospital discharge to ensure proper post hospital care. Findings included: During an interview on at 9:00 A.M. Resident #1 stated that she experienced two or three in the facility and was transported to the hospital after each incident. She stated that	A 162		

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A 162	Continued From page 25 one occurred while she was using her walker and did not apply the brakes, which resulted in a , and rescue transported her to the hospital. A review of Resident #1's record shows that the 1823 health assessment form dated lists diagnoses of ( ), , , and . The form documents the resident's status as alert and oriented times four (AOx4). It also showed that Resident #1 is independent with activities of daily living such as self care (grooming) and toileting, requires supervision for ambulation, bathing, and , and needs assistance with bathing, , toileting, and transferring. Progress notes indicate that Resident #1 was sent to the hospital due to a , and popping of the , border. On , Resident #1 returned to the facility. Further review of the record shows no documentation of the hospital discharge or a new health assessment following the resident's return. 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 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	A 165		

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A 165	Continued From page 26 develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's 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	A 165		

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A 165	Continued From page 27 this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section.	A 165		

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	AL11968520	A. BUILDING: _____ B. WING _____	06/22/2026

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A 165	Continued From page 28 This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that a preliminary adverse incident report was reported to the Agency of Health Care Administration (AHCA) within one day, for one out of 15 sampled residents (Resident #1). Findings included: During an interview on at 9:00 A.M. Resident #1 stated that she experienced two or three in the facility and was transported to the hospital after each incident. She stated that one occurred while she was using her walker and did not apply the brakes, which resulted in a , and rescue transported her to the hospital. A review of the Agency Intake Report System (AIRS) showed that there was no adverse incident report for Resident #1 filed by the facility for a , . A review of Resident #1's health assessment (Form 1823) dated showed the residents are alert and oriented times 4 (AOX4). Furthermore, progress notes reviled that Resident #1 was sent to the hospital due to a , and popping of the , border. On Resident #1 returned to the facility. Class III	A 165		
A 182 SS=I	59A-36.019(3) FAC Emergency Mgmt - Plan Implementation (3) PLAN IMPLEMENTATION.	A 182		

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A 182	Continued From page 29 (a) All staff must be trained in their duties and are responsible for implementing the emergency management plan. New staff must be trained on the plan within 30 days of employment. (b) If telephone service is not available during an emergency, the facility must request assistance from local law enforcement or emergency management personnel in maintaining communication This Statute or Rule is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure that three of fifteen sampled staff had been trained and understood their responsibilities for implementing the emergency management plan Staff F, J and R). Findings include: On at 6:15 AM, observation showed that only Staff F (Registered Nurse), Staff J (Certified Nursing Assisstant), and Staff R (Certified Nursing Assisstant) from the night shift were taking care of all the residents. On at 6:15 AM, during an interview, Staff J stated that she did not know the census. She also stated that, in the event of an emergency evacuation, they would not use the elevators and would evacuate residents using wheelchairs. On at 6:25 AM, during an interview Staff F stated, "I believe the census is around 120," but added, "I can't give you that exact number." Observation on at 8:15 AM, during the tour of the kitchen area, it was observed that	A 182		

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A 182	Continued From page 30 there was no nonperishable food stored for use in case of an emergency. On , during the interview, the Administrator stated that all the food in the kitchen would be used in an emergency, that an order had been placed with the food provider at the beginning of the year, that he believed they had "more than enough food." On at 10:00 AM, during the interview Staff N (receptionist) didn't know the census, also didn't know how to turns the generator on. On at 6:00 AM, during an interview, Staff M (Receptionist) stated that she did not know the facility census or how many residents were in the building. She stated, "I didn't know; I wouldn't want to give you the wrong number, I had to ask my supervisor." On at 6:20 AM, during an interview with Staff G (Registered Nurse) He stated that didn't know the census. On at 6:55 AM, during the interview Staff G stated that in an emergency residents would be evacuated by the stairs, and bedbound residents would have to wait for the fire department. When asked if there was any device to assist with evacuation using the emergency stairs, he stated there was none. On at 9:35 AM, during the interview, the Administrator did not know the census. He stated, "I don't know the exact number of residents, you know what day of the week it is today come on." A review of the emergency food list revealed that	A 182		

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A 182	Continued From page 31 there was insufficient food to feed the residents for 72 hours during an emergency. Class II	A 182		
A 190 SS=F	59A-36.023( ) & (3)(b) 429.14(6) FS Administrative Enforcement 59A-36.023( ) & (3)(b) FAC Facility staff must cooperate with agency personnel during surveys, complaint investigations, monitoring visits, license application and renewal procedures and other activities necessary to ensure compliance with Part II, Chapter 408, F.S., Part I, Chapter 429, F.S., Rule Chapter 59A-35, F.A.C., and this rule chapter. 429.41(5) The agency may use an abbreviated biennial standard licensure inspection that consists of a review of key quality-of-care standards in lieu of a full inspection in a facility that has a good record of past performance. However, a full inspection must be conducted in a facility that has a history of class I or class II violations, uncorrected class III violations; or a class I, Class II, or uncorrected class III violation resulting from a complaint referred by the State Long-Term Care Ombudsman Program, within the previous licensure period immediately preceding the inspection or if a potentially serious problem is identified during the abbreviated inspection. (1) Abbreviated Survey. (a) An applicant for license renewal who does not have any class I or class II violations or uncorrected class III violations, confirmed long-term care ombudsman program complaints, or confirmed licensing complaints within the two licensing periods immediately preceding the	A 190		

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A 190	Continued From page 32 current renewal date, is eligible for an abbreviated biennial survey by the agency. For the purpose of this rule, a confirmed long-term care ombudsman program complaint is a complaint that is verified and referred to a regulatory agency for further action. Facilities that do not have two survey reports on file with the agency under current ownership are not eligible for an abbreviated inspection. Upon arrival at the facility, the agency must inform the facility that it is eligible for an abbreviated survey, and that an abbreviated survey will be conducted. (b) Compliance with key quality of care standards described in the following statutes and rules will be used by the agency during its abbreviated survey of eligible facilities: 1. Section 429.26, F.S., and Rule 59A-36.006, F.A.C., relating to residency criteria; 2. Section 429.27, F.S., and Rule 59A-36.013, F.A.C., relating to proper management of resident funds and property; 3. Section 429.28, F.S., and Rule 59A-36.007, F.A.C., relating to respect for resident rights; 4. Section 429.41, F.S., and Rule 59A36.007, F.A.C., relating to the provision of supervision, assistance with the activities of daily living, and arrangement for , , and transportation to , , ; 5. Section 429.256, F.S., and Rule 59A-36.008, F.A.C., relating to assistance with or administration of medications; 6. Section 429.41, F.S., and Rule 59A-36.010, F.A.C., relating to the provision of sufficient staffing to meet resident needs; 7. Section 429.41, F.S., and Rule 59A-36.012, F.A.C., relating to minimum dietary requirements and proper food hygiene; 8. Section 429.075, F.S., and Rule 59A-36.020, F.A.C., relating to mental health 'residents'	A 190		

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A 190	Continued From page 33 community support living plan; 9. Section 429.07, F.S., and Rule 59A-36.021, F.A.C., relating to meeting the environmental standards and residency criteria in a facility with an extended congregate care license; and 10. Section 429.07, F.S., and Rule 59A-36.022, F.A.C., relating to the provision of care and staffing in a facility with a limited nursing services license. (c) The agency will expand the abbreviated survey or conduct a full survey if violations which threaten or potentially threaten the health, safety, or welfare of residents are identified during the abbreviated survey. The facility must be informed when a full survey will be conducted. If one or more of the following serious problems are identified during an abbreviated survey, a full biennial survey will be immediately conducted: 1. Violations of Rule Chapter 69A-40, F.A.C., relating to firesafety, that threaten the life or safety of a resident; 2. Violations relating to staffing standards or resident care standards that adversely affect the health, safety, or welfare of a resident; 3. Violations relating to facility staff rendering services for which the facility is not licensed; or 4. Violations relating to facility medication practices that are a threat to the health, safety, or welfare of a resident. (2) Survey Deficiency. (a) Before or in conjunction with a notice of violation issued pursuant to Part II, Chapter 408, F.S., and Section 429.19, F.S., the agency shall issue a statement of deficiency for class I, II, III, and violations which are observed by agency personnel during any inspection of the facility. The deficiency statement must be issued within 10 working days of the agency's inspection and	A 190		

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A 190	Continued From page 34 must include: 1. A description of the deficiency; 2. A citation to the statute or rule violated; and 3. A time frame for the correction of the deficiency. (b) Additional time may be granted to correct specific deficiencies if a written request is received by the agency before the expiration of the time frame included in the agency's statement. (3)(b) Dietary Deficiencies. 1. If a class I, class II, or uncorrected class III deficiency directly related to dietary standards as established in Rule 59A-36.012, F.A.C., is documented by agency pursuant to an inspection of the facility, the agency must notify the facility in writing that the facility must employ or contract the services of a registered or licensed dietitian, or a licensed nutritionist. 2. The initial on-site consultant visit must take place within seven working days of the notice of a class I or II deficiency or within 14 working days of the notice of an uncorrected class III deficiency. The facility must have available for review by the agency a copy of the license or registration of the consultant dietitian or nutritionist and the consultant's signed and dated review of the facility's corrective action plan, if a plan is required by the agency, no later than 10 working days after the initial onsite consultant visit. 3. If a corrective action plan is required, the facility must provide the agency with, at a minimum, quarterly onsite corrective action plan updates until the agency determines after written notification by the dietary consultant and facility administrator, that deficiencies are corrected and staff has been trained to ensure that proper	A 190		

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A 190	Continued From page 35 dietary standards are followed and consultant services are no longer required. The agency must provide the facility with written notification of such determination. 429.14 (6) As provided under s. 408.814, the agency shall impose an immediate moratorium on an assisted living facility that fails to provide the agency with access to the facility or prohibits the agency from conducting a regulatory inspection. The licensee may not restrict agency staff from accessing and copying records at the agency's expense or from conducting confidential interviews with facility staff or any individual who receives services from the facility. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to cooperate with the agency personnel during survey. The Administrator did not provide requested facility records. Findings include: During an interview on at 11:20 AM, the Administrator stated "okay." When asked to provide liability insurance, elopement and fire drills, and CEMP (Comprehensive Emergency Management Plan). A review of facility records revealed the Administrator only provided the Department of Health inspection. During an interview on at 7:45 AM, the Administrator stated he would provide all requested documents as soon as possible. When	A 190		

Agency for Health Care Administration

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A 190	Continued From page 36 asked to provide residents' charts. During an interview on at 11:00 AM, the Administrator stated he would bring the records as soon as possible. When reminded again about the pending residents records requested. Furthermore, the Administrator provided the requested residents' records at 11:59 PM. Class III	A 190		