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
	AL11953272	A. BUILDING: _____ B. WING _____	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD RETIREMENT CENTER	1220 JIMMY ANN DRIVE DAYTONA BEACH, FL 32117

(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
CZ841	408.823(1-2) FS In-person Visitation (1) This section applies to developmental disabilities centers as defined in s. 393.063, hospitals licensed under chapter 395, nursing home facilities licensed under part II of chapter 400, hospice facilities licensed under part IV of chapter 400, intermediate care facilities for the developmentally disabled licensed and certified under part VIII of chapter 400, and assisted living facilities licensed under part I of chapter 429. (2)(a) No later than 30 days after the effective date of this act, each provider shall establish visitation policies and procedures. The policies and procedures must, at a minimum, include infection control and education policies for visitors; screening, personal protective equipment, and other infection control protocols for visitors; permissible length of visits and numbers of visitors, which must meet or exceed the standards in ss. 400.022(1)(b) and 429.28(1)(d), as applicable; and designation of a person responsible for ensuring that staff adhere to the policies and procedures. Safety-related policies and procedures may not be more stringent than those established for the provider's staff and may not require visitors to submit proof of any vaccination or immunization. The policies and procedures must allow consensual physical contact between a resident, client, or patient and the visitor. (b) A resident, client, or patient may designate a visitor who is a family member, friend, guardian, or other individual as an essential caregiver. The provider must allow in-person visitation by the essential caregiver for at least 2 hours daily in addition to any other visitation authorized by the provider. This section does not require an essential caregiver to provide necessary care to a resident, client, or patient of a provider, and	CZ841		

AHCA Form 3020-0001

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

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CZ841	Continued From page 1 providers may not require an essential caregiver to provide such care. (c) The visitation policies and procedures required by this section must allow in-person visitation in all of the following circumstances, unless the resident, client, or patient objects: 1. End-of-life situations. 2. A resident, client, or patient who was living with family before being admitted to the provider ' s care is struggling with the change in environment and lack of in-person family support. 3. The resident, client, or patient is making one or more major medical decisions. 4. A resident, client, or patient is experiencing emotional distress or grieving the loss of a friend or family member who recently died. 5. A resident, client, or patient needs cueing or encouragement to eat or drink which was previously provided by a family member or caregiver. 6. A resident, client, or patient who used to talk and interact with others is seldom speaking. 7. For hospitals, childbirth, including labor and delivery. 8. Pediatric patients. (d) The policies and procedures may require a visitor to agree in writing to follow the provider's policies and procedures. A provider may suspend in-person visitation of a specific visitor if the visitor violates the provider's policies and procedures. (e) The providers shall provide their visitation policies and procedures to the agency when applying for initial licensure, licensure renewal, or change of ownership. The provider must make the visitation policies and procedures available to the agency for review at any time, upon request. (f) Within 24 hours after establishing the policies and procedures required under this section,	CZ841		

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CZ841	Continued From page 2 providers must make such policies and procedures easily accessible from the homepage of their websites. This Statute or Rule is not met as evidenced by: Based on interview and record review the facility failed to establish visitation policies and procedures applicable to the three residents of the facility. The findings include: During an interview with the Administrator on 7/16/2024 at 11:25am, she was asked to provide the facility's visitation policy. She stated she wasn't sure where it was located. She stated her previous Administrative Assistant handled that and she was no longer in the facility. A review of facility records did not produce any visitation policies. During a follow up interview with the Administrator on 7/16/2024 at 12:59pm she stated her previous Administrative Assistant still helped her by checking her emails and telling her what she needed to do. A visitation policy was not prouced by the time the survey ended. CLASS III	CZ841		
A 000	Initial Comments An abbreviated relicensure survey and complaint investigation, complaint #2023009630, was conducted at Lakewood Retirement Center on 7/16/2024. Deficiencies were identified in the relicensure survey.	A 000		

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A 078	Continued From page 3	A 078		
A 078	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable disease. The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative tuberculosis examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of tuberculosis testing materials satisfies the annual tuberculosis examination requirement. An individual with a positive tuberculosis test must submit a health care provider's statement that the individual does not constitute a risk of communicating tuberculosis. 2. If any staff member has, or is suspected of having, a communicable disease, such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable disease. (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their	A 078		

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A 078	Continued From page 4 responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility contracting to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff contracted by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure within 30 days after beginning employment, 1 of 2 employees, Employee A, submitted a written statement from a health care provider documenting that the individual did not have any signs or symptoms of communicable disease. The facility also failed to ensure evidence of a negative tuberculosis (TB) examination was documented on an annual basis for 2 of 2 employees, Employee A and the Administrator. The facility mailed to ensure contracted staff were knowledgeable in their	A 078		

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A 078	Continued From page 5 duties when providing care and services to the 3 residents of the facility. The findings include: 1. During an interview conducted on 7/16/2024 at 10:45am with Employee A she stated she had been employed at the facility for nearly 2 years. She stated her job title was Housekeeper. On 7/16/2024 at 11:31am Employee A was observed preparing lunch for the residents, assisted them to their seats. On 7/16/2024 at 12:11pm she was observed with 2 residents engaging in an outdoor activity. An interview was conducted on 7/16/2024 at 2:12pm with the Administrator. She was asked to provide evidence of her negative TB examination. She stated she didn't have that on hand. She stated her previous Administrative Assistant handled all of that and was no longer in the facility. She had the chest X-ray due to medical issues however, she was not sure how long ago it was. During the interview the Administrator requested that Employee A report to the kitchen to assist with cooking the meal. Multiple requests were made to obtain a personnel file for Employee A on 07/16/2024. During an interview on 7/16/2024 at 12:59pm the Administrator confirmed she was unable to obtain the personnel file for Employee A. There was no documentation from a health care provider provided to show that Employee A did not have any signs or symptoms of communicable disease. There was also no evidence of a negative TB examination. There was no documentation to show Employee A had been educated on the facility's do not resuscitate order policy, resident rights, recognizing and preventing	A 078		

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A 078	Continued From page 6 abuse and neglect, emergency management procedures, elopement procedures, or nutrition and safe food handling. CLASS III	A 078		
A 083	59A-36.011(5) FAC Training - First Aid and CPR (5) FIRST AID AND CARDIOPULMONARY RESUSCITATION (CPR). A staff member who has completed courses in First Aid and CPR and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current CPR certification that requires the student to demonstrate, in person, that he or she is able to perform CPR and which is issued by an instructor or training provider that is approved to provide CPR training by the American Red Cross, the American Heart Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to maintain evidence that a staff member with current credentials in First Aid and Cardiopulmonary Resuscitation (CPR) was in the facility at all times to provide care to the 3 residents of the facility in the event these services	A 083		

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A 083	Continued From page 7 were needed. The findings include: During an entrance conference conducted 7/16/2024 at approximately 9:25am the Administrator, she stated there are only two employees at the facility, Employee A and herself. She stated she was in the facility 24/7 and Employee A worked days and picked up shifts as needed. She was asked to provide personnel files for herself and Employee A. She stated Employee A has been employed with her for more than a year through an agency. She stated she did not keep an employee file for her in the facility. Record review revealed the Administrator last completed a course in First Aid and CPR on 11/16/2021 which was to be renewed by 11/2023. During an interview on 7/16/2024 at 2:12 with the Administrator was advised of missing training documentation for herself and Employee A, including First Aid and CPR. She stated her previous Administrative Assistant handled that and she is no longer in the facility. She stated she did not know where the documentation was located. During an interview on 7/16/2024 at 4:56pm with the Administrator she confirmed she did not have evidence that she or Employee A had completed courses in First Aid and CPR. The Administrator failed to provide any documentation by the end of the survey to show the facility had around the clock coverage of personnel with First Aid and CPR certification.	A 083		

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A 083	Continued From page 8 CLASS III	A 083		
A 084	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for infection control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates,	A 084		

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A 084	Continued From page 9 in person and both physically and verbally, the ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, topical dosage forms, and topical ophthalmic, otic and nasal dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with insulin syringes that are prefilled with the proper dosage by a pharmacist and insulin pens that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection; i. Assist with nebulizers; j. Use a glucometer to perform blood glucose testing; k. Assist residents with oxygen nasal cannulas and continuous positive airway pressure (CPAP) devices, excluding the titration of the oxygen levels; l. Apply and remove anti-embolism stockings and	A 084		

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A 084	Continued From page 10 hosiery; m. Placement and removal of colostomy bags, excluding the removal of the flange or manipulation of the stoma site; and, n. Measurement of blood pressure, heart rate, temperature, and respiratory rate. (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training This Statute or Rule is not met as evidenced by:	A 084		

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A 084	Continued From page 11 Based on observation and interview, the facility failed to ensure staff assisting with the self-administration of medications completed the required training, for 1 of 2 employees sampled, the Administrator. The findings include: Resident #1 was observed receiving assistance with self administration of medication from the Administrator on 7/16/2024 at 4:27pm. Resident #2 was observed receiving assistance with self administration of medication from the Administrator on 7/16/2024 at 4:35pm. Record review revealed no evidence the Administrator had received the two hours of continuing education required annually after completing the six hours of training required to provide assistance with self-administration of medication. An interview was conducted on 7/16/2024 at 4:56pm with the Administrator. She confirmed she had not completed the required annual 2 hour update training in assisting with self-administration of medication. CLASS III	A 084		
A 085	59A-36.011(7) FAC Training - Nutrition & Food Service (7) NUTRITION AND FOOD SERVICE. The administrator or person designated by the administrator as responsible for the facility's food service and the day-to-day supervision of food service staff must obtain, annually, a minimum of	A 085		

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A 085	Continued From page 12 2 hours continuing education in topics pertinent to nutrition and food service in an assisted living facility. This requirement does not apply to administrators and designees who are exempt from training requirements under paragraph 59A-36.012(1)(b). A certified food manager, licensed dietician, registered dietary technician or health department sanitarian is qualified to train assisted living facility staff in nutrition and food service. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure the food service designee participated annually in a minimum of 2 hours continuing education in topics pertinent to nutrition and food service in an assisted living facility for three of three years sampled. The findings include: Review of the Administrator's personnel file revealed she last received the 2 hours continuing education in topics pertinent to nutrition and food service in an assisted living facility on 4/15/21. No food service continuing education was located for 2022, 2023, or 2024. On 7/16/2024 at 2:12pm, the Administrator was observed in the kitchen. She stated she was preparing dinner. At this time she was advised that the continuing education for nutrition and food service was needed. She stated her previous Administrative Assistant handled all of that and she would have to look for it. She stated she did not know where they were. An interview was conducted with the Administrator on 7/16/2024 at 4:56pm. She confirmed she did not have the 2 hours of	A 085		

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A 085	Continued From page 13 continuing education in topics pertinent to nutrition and food service in an assisted living facility. CLASS III	A 085		
A 093	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a 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	A 093		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD RETIREMENT CENTER	1220 JIMMY ANN DRIVE DAYTONA BEACH, FL 32117

(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 093	Continued From page 14 nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is 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	A 093		

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A 093	Continued From page 15 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 calculating 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 hand. (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has contracted with residents to serve, must be on hand 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 interview and record review, the facility failed to maintain evidence that regular and therapeutic menus used by the facility for meals provided to the 3 residents of the facility were reviewed annually.	A 093		

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A 093	Continued From page 16 The findings include: During an entrance conference conducted 7/16/2024 at approximately 9:25am the Administrator was asked to provide all regular and therapeutic menus used by the facility. On 7/16/2024 at 11:38am the Administrator was asked a second time for the menus and substitution log. She responded there are only three people in the facility and they don't have a problem with food adding, the people eat well. During an interview on 7/16/2024 at 12:20pm with the Administrator she stated she was unable to locate the signed menus. She stated she had one in the kitchen and the painters may have moved it. She stated the facility was undergoing updates and she was not sure where a lot of things were. CLASS III	A 093		
A 200	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	A 200		

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A 200	Continued From page 17 equipped to ensure ambient 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 feet per resident must be provided. The assisted living facility may use eighty percent (80%) of its licensed bed capacity as the number of residents to be used in the calculation 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,	A 200		

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A 200	Continued From page 18 this rule does not limit the types of systems or equipment that may be used to achieve ambient 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 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 ambient temperatures at or below 81 degrees Fahrenheit	A 200		

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A 200	Continued From page 19 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 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 carbon monoxide alarm. (2) SUBMISSION OF THE PLAN. (a) Each new assisted living facility shall submit	A 200		

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A 200	Continued From page 20 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 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 200		

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A 200	Continued From page 21 (a) Each assisted living facility licensed prior to the effective date of this rule shall, no later than June 1, 2018, 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 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 ambient 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 dehydration and heat injury; and 4. A provision for obtaining medical intervention	A 200		

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A 200	Continued From page 22 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 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 200		

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A 200	Continued From page 23 (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 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 interview and observation, the facility failed to maintain policies and procedures on the operation and maintenance of the fixed generator for staff to reference for emergency management purposes. This has potential to affect all three residents of the facility in the event power is lost. The findings include: During an interview with the Administrator on 7/16/2024 at 11:25am,the Administrator stated	A 200		

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A 200	Continued From page 24 the facility had a fixed generator however, she was not able to provide any additional information. She could not produce any service receipts or fuel invoices. She stated her previous Administrative Assistant handled all of that and was no longer in the facility. During a tour of the outside of the facility at 2:58pm observed a fixed Generac generator. The Administrator was not able to provide any information on the operation and maintenance of the generator. CLASS III	A 200		
CZ816	408.809(2) 435.05(2) 59A-35.090(2d-3b) Background Screening-Compliance Attestation 408.809 Background screening; prohibited offenses.- (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's fingerprints to the Federal Bureau of Investigation for a national criminal history record check unless the person's fingerprints are enrolled in the Federal Bureau of Investigation's national retained print arrest notification program. If the fingerprints of such a person are not retained by the Department of Law Enforcement under s.	CZ816		

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CZ816	Continued From page 25 943.05(2)(g) and (h), the person must submit fingerprints electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the fingerprints to the Federal Bureau of Investigation for a national criminal history record check. The fingerprints shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print arrest notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person fingerprinted. The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that: (a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section; (b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and (c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency. 435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered	CZ816		

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CZ816	Continued From page 26 employees and employers: (2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer. 59A-35.090 Background Screening. (2) Processing Screening Requests, Required Documents and Fees. (d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, January 2017, herein incorporated by reference, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-09106, and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Regulations_Forms.shtml. This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if arrested for any disqualifying offense. (e) An administrator or chief financial officer must be screened and qualified prior to appointment to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at:	CZ816		

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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
CZ816	Continued From page 27 apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the arrest report and court disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to Section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with Section 435.06(3), F.S. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide proof that 1 of 2 employees sampled, Employee A, completed a Level II background rescreening every 5 years prior to working unsupervised with residents. The findings include: During an entrance conference conducted 7/16/2024 at approximately 9:25am the Administrator was asked to provide personnel files for herself and Employee A. She stated Employee A has been employed with her for more than a year through an agency. She stated she did not keep an employee file for her in the facility. She stated Employee A worked during the day and would also cover a shift for her as needed. On 7/16/2024 at 11:31am Employee A was observed preparing lunch for the residents. Employee A made the residents plates and assisted them to their seats. After resident's finished their meals, she gathered their dishes and returned them to the kitchen. The	CZ816		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11953272	A. BUILDING: _____ B. WING _____	07/16/2024

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CZ816	Continued From page 28 Administrator was not present. On 7/16/2024 at 12:11pm Employee A was observed with 2 residents engaging in an outdoor activity. Again, the Administrator was not present. During an interview conducted on 7/16/2024 at 10:45am with Employee A she stated she had been employed at the facility for nearly 2 years. She stated her job title was Housekeeper. The Administrator provided timesheets for Employee A. The documentation provided revealed Employee A worked 4/23-4/27/2024, 4/29-30/2024, 5/1/2024, 6/10-12/2024, 6/14/2024, 6/17/2024, 6/29/2024, 7/1-5/2025. Photographic evidence obtained. Record review revealed the Level II background screening for Employee A was not listed as eligible. The last screening was completed on 9/2/2020. The fingerprints retained were expired and a new screening for employment was required. Photographic evidence obtained. The findings were reviewed with the Administrator on 7/16/2024 at 4:07pm. She confirmed she did not have a personnel file for Employee and could not provide the requested documentation. Unclassified	CZ816		
CZ830	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a	CZ830		

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CZ830	Continued From page 29	CZ830		

safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows:
(a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan.
(b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan.
(c) Submit necessary plan revisions within 30 days after notification that plan revisions are required.
(d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health.
(2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers.
(3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider:
1. Suffered damage to its operation during the state of emergency.

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CZ830	Continued From page 30 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility	CZ830		

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CZ830	Continued From page 31 failed to submit the comprehensive emergency management plan (CEMP), applicable to all residents in the event of an emergency, on an annual basis. The findings include: During an interview with the Administrator on 7/16/2024 at 11:25am, she was asked to provide the facility's CEMP. She stated it was not completed. She was asked to provide the most recent approval. She stated she would have to look for it. During an interview with the Administrator on 7/16/2024 at 12:59pm she stated her previous Administrative Assistant still helps her by checking her emails and telling her what she needs to do. She was unable to produce evidence she resubmitted her CEMP annually to the county emergency management office. CLASS III	CZ830		