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
	AL11965867	A. BUILDING: _____ B. WING _____	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUNNINGHAM ELDERLY, LLC	2909 COURTLAND BLVD DELTONA, FL 32738

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ZZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the fingerprints are enrolled in the national retained print arrest notification program at the Federal Bureau of Investigation: 1. A person with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. 2. Effective January 1, 2026, or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity. (c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse. 1. Before January 1, 2024, initial status and any changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person ' s status has been made. 2. Effective January 1, 2024, initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person ' s status has been made.	ZZ814		

AHCA Form 3020-0001

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

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ZZ814	Continued From page 1 (d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic fingerprint submission to the Department of Law Enforcement. The registration must include the person ' s full first name, middle initial, and last name; social security number; date of birth; mailing address; sex; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to register 1 of 3 sampled employees on its Background Screening Clearinghouse Roster within 5 days of employment (Employee A). The findings include: Review of Employee A's file showed he was hired as a caregiver on 03/04/2024. Review of the facility schedule showed that when the Administrator left at 7pm, he was scheduled to work alone until Employee C arrived for her 10pm shift. Photographic evidence obtained. Review of the online Clearinghouse Roster for the facility on 03/12/2025 showed Employee A's name was not listed. Employee A's individual screening did not list the same of the facility in his employment history. Photographic evidence obtained.	ZZ814		

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ZZ814	Continued From page 2 The findings were reviewed with the Administrator on 03/11/2025 at 2:16pm. She was shown the online database and confirmed Employee A was missing. Unclassified	ZZ814		
ZZ816	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. 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	ZZ816		

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ZZ816	Continued From page 3 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 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.	ZZ816		

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ZZ816	Continued From page 4 (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: 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	ZZ816		

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ZZ816	Continued From page 5 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 record review and interview, the facility failed to ensure 2 of 3 sampled employees (Employee A and B) signed an Attestation of Compliance with Background Screening Requirements. The findings include: Review of the records for Employees A and B showed they both has copies of the AHCA Affidavit of Compliance with Background Screening Requirements in their personnel files. Both copies were blank and no information was filled in on any pages. The findings were reviewed with the Administrator on 03/11/2025 at 2:16pm. She confirmed the forms needed signatures. Unclassified	ZZ816		
ZZ875	430.5025(4 & 7-9) Alzheimer disease/dementia; Training (4) Employees of covered providers must complete the following training for Alzheimer's disease and related forms of dementia: (a) Upon beginning employment, each employee must receive basic written information about interacting with persons who have Alzheimer's disease or related forms of dementia. (b) Within 30 days after beginning employment, each employee who provides personal care to or	ZZ875		

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ZZ875	Continued From page 6	ZZ875		

has regular contact with participants, patients, or residents must complete a 1-hour training program provided by the department.
1. The department shall provide training that is available online at no cost. The 1-hour training program shall contain information on understanding the basics about the most common forms of dementia, how to identify the signs and symptoms of dementia, and skills for communicating and interacting with persons with Alzheimer ' s disease or related forms of dementia. A record of the completion of the training program must be made available to the covered provider which identifies the training curricula, the name of the employee, and the date of completion.
2. A covered provider must maintain a record of the employee's completion of the training program and, upon written request of the employee, provide the employee with a copy of the record of completion consistent with the employer's written policies.
3. An employee who has completed the training required in this subsection is not required to repeat the program upon changing employment to a different covered provider.
(c) Within 7 months after beginning employment for a home health agency, nurse registry, or companion or homemaker service provider, each employee who provides personal care must complete 2 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person ' s independence in activities of daily living, and skills in working with families and caregivers.
(d) Within 7 months after beginning employment for a nursing home, an assisted living facility, an adult family-care home, or an adult day care

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ZZ875	Continued From page 7	ZZ875		

center, each employee who provides personal care must complete 3 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, skills in working with families and caregivers, group and individual activities, maintaining an appropriate environment, and ethical issues.
(e) For an assisted living facility, adult family-care home, or adult day care center that advertises and provides, or is designated to provide, specialized care for persons with Alzheimer's disease or related forms of dementia, in addition to the training specified in paragraphs (a) and (b), employees must receive the following training:
1. Within 3 months after beginning employment, each employee who provides personal care to or has regular contact with the residents or participants must complete the additional 3 hours of training as provided in paragraph (d).
2. Within 6 months after beginning employment, each employee who provides personal care must complete an additional 4 hours of dementia-specific training. Such training must include, but is not limited to, understanding Alzheimer's disease and related forms of dementia, the stages of Alzheimer's disease, communication strategies, medical information, and stress management.
3. Thereafter, each employee who provides personal care must participate in at least 4 hours of continuing education each calendar year through contact hours, on-the-job training, or electronic learning technology. For this subparagraph, the term "on-the-job training" means a form of direct coaching in which a facility administrator or his or her designee instructs an employee who provides personal care with

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ZZ875	Continued From page 8 guidance, support, or hands-on experience to help develop and refine the employee's skills for caring for a person with Alzheimer's disease or a related form of dementia. The continuing education must cover at least one of the topics included in the dementia-specific training in which the employee has not received previous training in the previous calendar year. The continuing education may be fulfilled and documented in a minimum of one quarter-hour increments through on-the-job training of the employee by a facility administrator or his or her designee or by an electronic learning technology chosen by the facility administrator. On-the-job training may not account for more than 2 hours of continuing education each calendar year. (f)1. An employee provided, assigned, or referred by a health care services pool must complete the training required in paragraph (c), paragraph (d), or paragraph (e) that is applicable to the covered provider and the position in which the employee will be working. The documentation verifying the completed training and continuing education of the employee, if applicable, must be provided to the covered provider upon request. 2. A health care services pool must verify and maintain documentation as required under s. 400.980(5) before providing, assigning, or referring an employee to a covered provider. (7) For a certified nursing assistant as defined in s. 464.201, training hours completed as required under this section may count toward the total hours of training required to maintain certification as a nursing assistant. (8) For a health care practitioner as defined in s. 456.001, training hours completed as required under this section may count toward the total hours of continuing education required by that practitioner's licensing board.	ZZ875		

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ZZ875	Continued From page 9 (9) Each person employed, contracted, or referred to provide services before July 1, 2023, must complete the training required in this section before July 1, 2026. Proof of completion of equivalent training completed before July 1, 2023, shall substitute for the training required in subsection (4). Each person employed, contracted, or referred to provide services on or after July 1, 2023, may complete training using approved curriculum under paragraph (5)(d) until the effective date of the rules adopted by the department under subsection (6). This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 3 sampled employees completed the Alzheimer's Disease and Related Disorder (ADRD) trainings in a timely manner (Employee A). The findings include: During an interview with Employee A on 03/11/2025 at 11:58am,, he explained he has worked as a caregiver at the facility for about a year. Employee A's personnel record was reviewed and did not produce any evidence of ADRD training. The findings were reviewed with the Administrator at 2:30pm. She was unaware of the ADRD online video and trainings and acknowledged the need for completion. Class III	ZZ875		

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A 000	Continued From page 10	A 000		
A 000	Initial Comments A relicensure survey was conducted at Cunningham Elderly on 03/11/2025. Deficiencies were identified at the time of the survey.	A 000		
A 032	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all	A 032		

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A 032	Continued From page 11 facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 3 of 3 direct care staff participated in 2 elopement drills per year. The findings include: Review of the facility's schedule showed 3 employees: the Administrator, Employee A,	A 032		

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A 032	Continued From page 12 Caregiver, and Employee C, Caregiver. Review of the facility's elopement drill records showed the Administrator and Employee C participated in a drill, based on an undated sign-in sheet. Photographic evidence obtained. No other drills were produced to show Employee A participated in any drills, or that the Administrator and Employee C had any additional drills. In an interview with Employee A on 03/12/2025 at 11:58am, he was asked about his participation in any elopement drills. An elopement drill was described and he said he hadn't participated in any. Review of the facility's Elopement Policy showed that all staff would participate in a drill at least two times per year. Photographic evidence obtained. The Administrator was interviewed on 03/11/2025 at 1:42pm and she confirmed there were no additional drills. Class III	A 032		
A 033	59A-36.007(8) PHYSICAL RESTRAINTS (8) PHYSICAL RESTRAINTS. Residents for whom a physician has prescribed a physical restraint must have a written care plan for the use of the physical restraint. The care plan must be developed within 14 days of the device being prescribed, and prior to use on the resident. (a) The care plan must specify: 1. The device prescribed for use; 2. The maximum amount of time the resident is to have the restraint applied each day; and, 3. In what manner and frequency staff will monitor, observe, and report to the physician any	A 033		

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A 033	Continued From page 13 injuries, increase in agitation, signs and symptoms of depression, or decline in mobility or function related to the use of the prescribed restraint. (b) Facility staff must ensure that the device is applied appropriately and safely. (c) The resident's physician must review the appropriateness of the continued use of the physical restraint annually, and documentation of this review must be maintained in the resident's record. If the resident's ability to independently remove or avoid the device fluctuates, the device must be considered a physical restraint and all requirements of this subsection apply. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure 3 of 6 sampled residents had a care plan developed for the use of restraints within 14 days of use. The findings include: At 11:58pm on 03/11/2025, Employee A, Caregiver, stated Residents 1,3, and 4 used bed rails. He said if they were in bed they wouldn ' t be able to remove or get around the bed rails independently. He was asked how long the residents were allowed to have the bed rails up, and he was not sure. He was unaware of any care plans that had been developed. During this interview, an observation was made of the bed rails on Resident 4's bed which had bed rails. An observation was made of the bed rails on Resident 1's bed during an interview with the Administrator at 2:38pm on 03/11/2025. She was asked about the use of bed rails on resident beds. She said she did not develop a care plan within 14 days and the requirement was	A 033		

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A 033	Continued From page 14 discussed. Review of Resident 1, 3, and 4's record showed documentation which ordered the rails, but nothing that detailed the maximum amount of time the rails would be used, or the manner and frequency staff would monitor, observe, and report issues to a physician. Class III	A 033		
A 036	59A-36.007(10) INFECTION CONTROL PROCEDURES (10) INFECTION CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of infectious diseases. (a) The facility must implement a hand hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to infectious materials or bodily fluids. Hand hygiene may include the use of alcohol-based rubs, antiseptic handwash, or handwashing with soap and water. (b) Standard precautions must be used when there is an anticipated exposure to transmissible infectious agents in blood, body fluids, secretions, excretions, nonintact skin, and mucuous membranes during the provision of personal services. Standard precautions include: hand hygiene, and dependent upon the exposure, use of gloves, gown, mask, eye protection, or a face shield. (c) The facility must clean and disinfect 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	A 036		

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A 036	Continued From page 15 recommendations. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to perform hand hygiene to prevent the spread of infection when working with 3 of 4 residents. The findings include: The Administrator was observed assisting Residents 1,3, and 4 with their breakfasts on 03/11/2025 at 9:15am. She fed Resident 3 by lifting the silverware with food to her mouth. Resident 1 was sitting next to Resident 3, and the Administrator then fed Resident 1 without performing hand hygiene. At 9:22am she was going between Resident 1 and 3 without performing hand hygiene, then walked over to Resident 4 and took his cup and brought it to his mouth for him to drink. She then returned to Residents 1 and 3, taking turns feeding each, and not performing hand hygiene since the meal began. After breakfast, the Administrator began preparing medications for Resident 4. She did not perform hand hygiene between helping residents eat and preparing medications for Resident 4. Review of the facility's hand hygiene policies included the direction to wash hands after potential exposure to contaminated surfaces or bodily fluids, and before and after having direct care with residents. Photographic evidence obtained. The observations were reviewed with the Administrator on 03/11/2025 at 2:45pm. She	A 036		

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A 036	Continued From page 16 acknowledged the importance of hand hygiene. Class III	A 036		
A 052	429.256(3-5); 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 insulin syringe that is prefilled with the proper dosage by a pharmacist and an insulin pen that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's hand or placing the dosage in another container and helping the resident by lifting the container to his or her mouth. (d) Applying topical medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives	A 052		

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A 052	Continued From page 17 assistance with self-administration under this section. (g) Assisting with the use of a nebulizer, including removing the cap of a nebulizer, opening the unit dose of nebulizer solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the nebulizer. (4) Assistance with self-administration of medication does not include: (a) Mixing, compounding, converting, or calculating 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 cavity of the body. (d) Administration of parenteral preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with rectal, urethral, or vaginal preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of	A 052		

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A 052	Continued From page 18 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 18 years of age or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as	A 052		

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A 052	Continued From page 19 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 infection control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to properly assist with self-administration of medication for 1 of 3 sampled residents (Resident 3). The findings include: At 9:51am on 03/11/2025, an observation was made of the Administrator assisting Resident 3	A 052		

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A 052	Continued From page 20 with self- administration of medications. The Administrator put her medications into a pill crusher and they were mixed into applesauce. Included in the pills that were crushed was a dose of Potassium. The Administrator stated she crushed the pills because Resident 3 could not swallow. Review of the Medication Observation Record (MOR) showed an entry for Potassium 10 meq, 1 tab by mouth daily. The entry stated "do not chew or crush- swallow." The pill bottle also had directions not to chew or crush. Photographic evidence obtained. The Administrator stated her pills were ordered by the hospice provider. She was asked for the order to crush the medications, but none were produced. A representative from the hospice provider arrived to the facility and the Administrator asked about the Potassium. The representative stated at 1:45pm on 03/11/2025 that the Potassium couldn't be crushed. At the time of the visit, the nurse wrote the order to crush medications and it was presented for review. Photographic evidence obtained. Class III	A 052		
A 054	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing	A 054		

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A 054	Continued From page 21 pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known allergies the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical restraints, the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Medication Observation Record (MOR) was accurate for 1 of 3 sampled residents (Resident 4). The findings include: During an observation of the Administrator assisting with Resident 4's medications on 03/11/2025 at 9:30am, she provided him Senna, Furosemide, and Pantoprazole after he finished eating his breakfast.	A 054		

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A 054	Continued From page 22 Review of the MOR for Pantoprazole showed the entry's instructions were to take one tablet each day before breakfast. The label did not include it needed to be taken before breakfast. Photographic evidence obtained. At 9:36am on 03/11/2025, the Administrator explained the order for Pantoprazole changed but the MOR was never updated. Class III	A 054		
A 076	59A-36.009 FAC Do Not Resuscitate Orders (DNROs) (1) POLICIES AND PROCEDURES. (a) Each assisted living facility must have written policies and procedures that explain its implementation of state laws and rules relative to Do Not Resuscitate Orders (DNROs). An assisted living facility may not require execution of a DNRO as a condition of admission or treatment. The assisted living facility must provide the following to each resident, or resident's representative, at the time of admission: 1. Form SCHS-4-2006, "Health Care Advance Directives - The Patient's Right to Decide," April 2006, or with a copy of some other substantially similar document, which incorporates information regarding advance directives included in chapter 765, F.S. Form SCHS-4-2006 is available from the Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 34, Tallahassee, FL 32308 or the agency's website at: http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/HC_Advance_Directives/docs/adv_dir.pdf; and,	A 076		

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A 076	Continued From page 23 2. DH Form 1896, Florida Do Not Resuscitate Order Form, December, 2004, which is hereby incorporated by reference. This form may be obtained by calling the Department of Health's toll free number 1(800)226-1911, extension 2780 or online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04005. (b) There must be documentation in the resident's record indicating whether a DH Form 1896 has been executed. If a DH Form 1896 has been executed, a yellow copy of that document must be made a part of the resident's record. If the assisted living facility does not receive a copy of a resident's executed DH Form 1896, the assisted living facility must document in the resident's record that it has requested a copy. (c) The executed DH Form 1896 must be readily available to medical staff in the event of an emergency. (2) LICENSE REVOCATION. An assisted living facility's license is subject to revocation pursuant to section 408.815, F.S., if, as a condition of treatment or admission, the facility requires an individual to execute or waive DH Form 1896. (3) DNRO PROCEDURES. Pursuant to section 429.255, F.S., an assisted living facility must honor a properly executed DH Form 1896 as follows: (a) In the event a resident experiences cardiac or pulmonary arrest, staff trained in cardiopulmonary resuscitation (CPR) or a health care provider present in the facility, may withhold cardiopulmonary resuscitation (artificial ventilation, cardiac compression, endotracheal intubation and defibrillation). (b) In the event a resident is receiving hospice services and experiences cardiac or pulmonary arrest, facility staff must immediately contact	A 076		

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A 076	Continued From page 24	A 076		

hospice staff. The hospice procedures take precedence over those of the assisted living facility.

This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain the code status information for 1 of 2 residents sampled.

The findings include:

Review of the employee file for Resident 3 showed no yellow copy of a Do Not Resuscitate Order (DNRO) in the record. Resident 3's file contained a copy of her Living Will and information about Advanced Directives. Nothing in the record documented the facility's attempts to determine whether Resident 3 wished to have a DNRO or if she would be full code.

Resident 3's file also contained a hospice plan of care dated 02/12/2025 which indicated on the first page that a DNRO was executed. Photographic evidence obtained.

A representative from Resident 3's hospice was interviewed at 1:39pm on 03/11/2025. She explained they had an executed DNR on file for Resident 3. The Administrator explained she did not have a copy of the form and thought Resident 3's spouse was against the DNRO.

At 2:05pm on 03/11/2025 the hospice representative informed the Administrator she could bring a copy of the DNRO to her for Resident 3's file. They discussed the possibility that Resident 3's spouse changed his mind. The Administrator then called Resident 3's spouse and while on speaker, he stated he did not remember executing a DNRO.

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A 076	Continued From page 25 The Administrator was interviewed again at 3:05pm on 03/11/2025. While reviewing Resident 3's file during the interview, she acknowledged it was not clear what Resident 3's code status was, based on the spouse's previous comment that he did not wish her to have a DNRO, but hospice saying they had an executed DNRO on file. Class III	A 076		
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	A 078		

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A 078	Continued From page 26 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 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 record review and interview, the facility	A 078		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965867	A. BUILDING: _____ B. WING _____	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUNNINGHAM ELDERLY, LLC	2909 COURTLAND BLVD DELTONA, FL 32738

(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 078	Continued From page 27 failed to ensure 1 of 3 sampled employees completed an annual TB examination (Employee A). The findings include: Review of Employee A's personnel file showed his last TB exam documentation was dated 03/06/2024. There was nothing in the record to show a TB exam past this date. The findings were reviewed with the Administrator on 03/11/2025 at 2:23pm. No additional TB testing was produced. Class III	A 078		
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 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 record review and interview, the facility failed to ensure the food service designee,	A 085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965867	A. BUILDING: _____ B. WING _____	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUNNINGHAM ELDERLY, LLC	2909 COURTLAND BLVD DELTONA, FL 32738

(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 085	Continued From page 28 responsible for the oversight of 4 residents' meal service, completed 2 hours of annual inservice training in food/nutrition-related topics. The findings include: Review of the Administrator's record on 03/11/2025 showed the last food and nutrition related inservice completed was on 02/16/2024. She was interviewed at 2:29pm on 03/11/2025 and confirmed her role as the food service designee. She did not have a more recent training certificate to provide. Class III	A 085		