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
	AL11968286	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTALLIS MANOR, LLC	2119 WILSON STREET HOLLYWOOD, FL 33020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced Relicensure and Generator Monitoring survey was conducted on at Christallis Manor, LLC. Deficiencies related to the Relicensure was identified at the time of survey.	A 000		
A 031	59A-36.007(6) FAC Resident Care - Third Party Services (6) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, , and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the , resident's needs. (c) The administrator or designee must ensure that: 1. Care coordination includes documented communications about the resident's condition	A 031		

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A 031	Continued From page 1 and response to treatment or services ordered by the physician which rnay impact the resident's appropriateness for continued residency in the facility; 2. Communications occur at least once every 30 days and whenever there is a significant change in the resident's condition; and 3. If physician ordered treatments or services occur less often than once a month, communications must be conducted according to the ordered treatment or service schedule and whenever there is a significant change in the resident's condition. 4. When communication with the third party provider is unsuccessful, at least two attempts at communication on two separate days must be documented. Documentation must include the name of the person from the third party provider with whom contact was attempted, the method of communication, and the date and time of the attempts. This documentation must be included in the resident's record in accordance with the timeframes in subparagraphs 59A-36.007(6)(c)2. and 3. (d) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain communications at least once every 30 days for 1 out of 2 sampled residents	A 031		

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A 031	Continued From page 2 (Resident #1) who was receiving third-party services from a home health agency. Additionally, the facility failed to ensure its policies required the third party to coordinate with the facility regarding the resident ' s condition and the services being provided. The findings include: During an interview with the Owner (Staff B) at 10:15 AM on . . . . . , she stated that the facility had one resident currently receiving from a home health agency (Resident #1). Documentation of the facility's third-party policy and the third-party communications for the resident were requested and provided. A review of the facility's third-party policy revealed no verbiage regarding the requirement for coordination of care related to the resident's condition and the services provided. Further review showed the policy did not indicate when or how the third party was supposed to document and provide communication with the facility. During a concurrent interview at 11:05 AM, the Administrator stated that the policy provided was the only policy she had and that it originated from the resident contract. No additional documentation was provided. During the survey on at approximately 12:30 PM, the home health agency Registered Nurse arrived to administer to Resident #1. The nurse was observed signing in to the visitor log, performing hygiene, and preparing the Accu-Check and administration materials. By 12:50 PM, the nurse had completed the administration and was observed documenting in a binder. There was no observed communication between the	A 031		

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A 031	Continued From page 3 Administrator and the Registered Nurse regarding the resident, the administration, or the resident ' s condition. Prior to her exit at approximately 1:00 PM, the Agency confirmed with the Registered Nurse that she was at the facility to perform administration for Resident #1 and that she was an employee of the affiliated home health agency. A review of the facility ' s third-party documentation that the Registered Nurse was using revealed a binder containing the following: -The facility's home health policy -A recertification for Resident #2's injections signed by a nurse practitioner (ARNP) -Daily Accu-Checks and Administration MARs for Resident #1 from to current (, was unsigned by a nurse) There was no documentation of any communication notes from the third-party provider to the facility regarding the resident ' s condition or the services provided. Additionally, the times of the visits were unrecorded. During an interview with the Owner on at 3:27 PM, she was notified that the facility failed to maintain documentation of any communication that identified coordination of care with the facility regarding the resident's condition and the services provided. She was also notified that the facility's policy and procedure did not clearly address the requirements for the third party to coordinate with the facility regarding the resident ' s condition and the services being provided. Class III.	A 031		

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A 033	Continued From page 4	A 033		
A 033	59A-36.007(8) PHYSICAL (8) PHYSICAL . Residents for whom a physician has prescribed a physical must have a written care plan for the use of the physical . 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 applied each day; and, 3. In what manner and frequency staff will monitor, observe, and report to the physician any injuries, increase in agitation, signs and symptoms of , , or decline in mobility or function related to the use of the prescribed . (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 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 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 the appropriate use of a physical for 1 of 2 sampled residents (Resident #1) by having a written care plan for the use of the physical within 14 days of the device being prescribed. The findings include:	A 033		

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A 033	Continued From page 5 A review of the facility's policy and procedures revealed there was no documentation of a policy related to the use of physical on file. On at 9:49 AM, during a tour of the facility, a semi-private room ( ) contained a bed on the left side of the room with a thin, frail male resident lying in it (Resident #1). The bed had double-sided full bedrails. A review of Resident #1's record showed an admission date of . Further review of the Resident Health Assessment (AHCA Form 1823) dated documented diagnoses of , , , , (left side), , and . The assessment also indicated the resident was bedbound and had full bedrails. Additionally, the resident required precautions and was a total assist with all activities of daily living, including toileting, transferring, and grooming. There was no documentation of a bedrail order on file. Furthermore, there was no documentation of a written care plan for the use of the physical within 14 days of the device being prescribed. During an interview with the Owner (Staff B) on at 3:35 PM, she was informed that Resident #1 did not have a written care plan for the use of the physical nor an order on file for the device. She was also reminded that the facility is required to maintain documentation of care plan reviews in the resident's file at all times. Class III	A 033		

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A 052	Continued From page 6	A 052		
A 052	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit	A 052		

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A 052	Continued From page 7 dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003.	A 052		

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A 052	Continued From page 8 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility,	A 052		

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A 052	Continued From page 9 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure 1 out of 1 sampled staff (Staff C) performed the procedure for assistance with self-administration correctly. This was evidenced by the failure to confirm the medication was intended for the resident and to announce medications. The findings include: During a medication pass for Resident #4 on at 12:27 PM, Staff C (HHA) was observed retrieving Resident #4's medication from the cart. The following medication was	A 052		

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A 052	Continued From page 10 retrieved: ACET 667 MG GELCAP TAKE ONE CAPSULE BY THREE TIMES EACH DAY Staff C then proceeded to pop open the bubble pack and provide Resident #4 with the medication without reviewing the Medication Observation Record (MOR) or the label. Staff C then closed the medication drawer and began signing the second page of the resident's MOR. A subsequent review of the MOR revealed that Resident #4 was supposed to receive an additional medication documented on the 3rd page of the MOR at noon: SEVELAMER TAB 800 MG TAKE 2 TABLETS 3 TIMES DAILY WITH MEALS AND 1 TABLET DAILY WITH SNACK The Agency intervened and notified Staff C that she had missed one of Resident #4's medications. Staff C then reviewed the MOR, identified the missing medication, and proceeded to assist with self-administration. No announcement of this medication was made to the resident, nor did Staff C confirm whether the resident had eaten prior to receiving the medication. During an interview with Staff C on at 3:00 PM, she stated that she had completed the initial 6-hour training for assistance with self-administration of medications and a 2-hour update in 2026. During an interview with the Owner(Staff B) on at 3:55 PM, she was notified that Staff C failed to review the MOR and label prior to	A 052		

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A 052	Continued From page 11 giving the resident medications, in addition to failing to announce medications. Class III	A 052		
A 056	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the	A 056		

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A 056	Continued From page 12 medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following:	A 056		

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A 056	Continued From page 13 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure medications were properly labeled and dispensed for 1 out of 2 sampled residents (Resident #4). This was evidenced by the facility's failure to ensure that physician orders matched the labels and directions on medications stored in the central medication storage. The findings include: A review of Resident #4 ' s file revealed a Resident Health Assessment (AHCA Form 1823) dated that documented diagnoses of , Systemic , Hypocalcemia, and of Metabolism. The resident was receiving as a treatment service and required assistance with self-administration of medications. Further review revealed a medication order dated from the resident's primary care provider that stated the following: -Discontinue 25 mg tablet - 1	A 056		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 056	Continued From page 14 tablet PO (twice a day, by) -Start , 50 mg tablet - 1 tablet PO (twice a day, by): hold if HR (rate) is less than 60 or (, ,) is less than or equal to 110 During a medication pass conducted with Staff C (HHA) on from 12:25 PM to 12:50 PM, the following medication was observed in the facility's central medication storage: Resident #4: , Tart 50 mg - Take one tablet by every 12 hours; Dx: , , Additionally, there was no , cuff observed in the medication cart. A review of the Medication Observation Record (MOR) for Resident #4 revealed that , had been administered daily since the change of order in . There was no documentation of any , readings for Resident #4 in the MOR. During an interview with Staff C on at 2:57 PM, she stated that she always took the resident's , in the morning. When asked why, Staff C stated that it was because the resident has high , . Documentation of Resident #4's , readings was requested but not provided. During an interview with the Owner (Staff B) on at 3:35 PM, she was notified that the facility failed to ensure the medication label for Resident #4's , matched the provider ' s order, including the , parameters. Staff B stated that her staff was performing the , daily. No	A 056		

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	AL11968286	A. BUILDING: _____ B. WING _____	10/01/2026

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A 056	Continued From page 15 additional documentation was provided. The Administrator was again notified that failure to follow the physician's order by administering the medication without documenting , readings could be detrimental to the resident's health. Class III	A 056		
A 152	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate	A 152		

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A 152	Continued From page 16 keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a safe, clean environment free of hazards for the entire resident census (4). The findings include: During a tour of the facility on from approximately 9:30 AM to 9:54 AM, the following concerns were identified: - Five nickel- to quarter-sized holes in the tiled flooring throughout the dining room, living room, and activity room area behind the kitchen. - Exposed, unpainted drywall patches in the activity room behind the kitchen. - A discarded cane, a scale with two bins stacked on top of it, an air-conditioning filter, four boxes, two mops, a broom, and a discarded shower chair observed in the activity area behind the kitchen. - A dirty, discarded, and unplugged freezer with a dirty pillow on top, a hose, a box containing a safety can for gasoline, and two walkers on the outdoor patio area. During an interview with the Administrator on at 3:40 PM, she was notified of the concerns identified during the tour and the	A 152		

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A 152	Continued From page 17 potential safety hazards posed by their presence in the facility. Class III.	A 152		
A 160	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to Rule 59A-36.018, F.A.C. If the resident dies while in the care of the	A 160		

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A 160	Continued From page 18	A 160		

facility, the log must indicate the date of .
(c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b).
(d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in Rule 59A-36.019, F.A.C., that must be readily available by facility staff.
(e) The facility's liability insurance policy required in Rule 59A-36.013, F.A.C.
(f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 59A-36.013, F.A.C.
(g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 59A-36.006, F.A.C.
(h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by Section 429.177, F.S.
(i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 59A-36.007, F.A.C.
(j) All food service records required in Rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate.
(k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.435, F.S., and rule Chapter 69A-40, F.A.C., issued within the last 2 years.
(l) All sanitation inspection reports issued by the

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A 160	Continued From page 19 county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.; (q) The facility's prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.; (w) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure it maintained required records in a manner that made such records readily available. The findings include: During an interview with the Owner on at 10:15 AM, a request was made for all facility documentation. Documentation was provided.	A 160		

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A 160	Continued From page 20 A review of the facility documentation revealed the following: - Missing Admission/Discharge Log - Missing Policies for Third Party Providers, Control, , Assistive Devices, Physical and Prevention - Missing 2025 fire safety inspection During an interview with the Owner on at 3:58 PM, she was notified of the missing facility documentation. No additional documentation was provided. Class	A 160		
A 162	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care	A 162		

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A 162	Continued From page 21 practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A ⌄ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their ⌄ recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that ⌄ not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written	A 162		

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A 162	Continued From page 22 statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No =Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be	A 162		

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A 162	Continued From page 23 retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure it maintained resident records on the premises that included the resident care record for 2 out of 2 sampled residents (Resident #1 and 4). The findings include: During an interview with the Owner on at 10:17 AM, a request was made for a sample of resident records. Documentation for Resident #1 and #4's resident records were provided. A review of Resident #1's record showed an admission date of . Further review of the Resident Health Assessment (AHCA Form 1823) dated documented diagnoses of , , , , , (left side), , and . The assessment also indicated the resident was bedbound, had full bedrails, and was under hospice and home health care (administration). Additionally, the resident required precautions and was a total assist with all activities of daily living, including toileting,	A 162		

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A 162	Continued From page 24 transferring, and grooming. A prior Resident Health Assessment dated documented diagnoses of (left side), and . The assessment also indicated the resident was bedbound under hospice care, required assistance with medications and ADLs as a nursing service, and was under home health care (administration). Additionally, the resident required precautions and was a total assist with all activities of daily living (ADLs); with the acceeption of eating (assistance). There was no documentation of resident care on file for the monitoring of administration, the change of condition that required the use of full bedrails, nor the ADL decline. A review of Resident #4's file revealed a Resident Health Assessment (AHCA Form 1823) dated that documented diagnoses of , Systemic , Hypocalcemia, and of Metabolism. The resident was receiving as a treatment service and required assistance with self-administration of medications. There was no documentation of resident care on file for the coordination of care, the resident's overall condition, nor the admission date. During an interview with the Owner on at 3:40 PM, she was notified that Resident's #1 and 4 were missing documentation in their file that clearly detailed the resident care they were receiving at the facility. No additional documentation was provided.	A 162		

Agency for Health Care Administration

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A 162	Continued From page 25 Class III	A 162		