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
	AL11969286	A. BUILDING: _____ B. WING _____	09/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEAN CARLOS ALF INC	9760 MEMORIAL RD CUTLER BAY, FL 33157

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation (complaint numbers 2019013341 and 2019012232) was conducted at Jean Carlos Alf Inc. on . Deficiencies were identified at the time of the survey.	A 000		
A 007 SS=D	429.26(11) FS; 58A-5.0181(1) FAC Admissions - Criteria 429.26 (11) No resident who requires 24-hour nursing supervision, except for a resident who is an enrolled hospice patient pursuant to part of chapter 400, shall be retained in a facility licensed under this part. 58A-5.0181 (1) ADMISSION CRITERIA. (a) An individual must meet the following minimum criteria in order to be admitted to a facility holding a standard, limited nursing services, or limited mental health license: 1. Be at least 2. Be free from signs and symptoms of any communicable that is likely to be transmitted to other residents or staff. An individual who has ( ) may be admitted to a facility, provided that the individual would otherwise be eligible for admission according to this rule. 3. Be able to perform the activities of daily living, with supervision or assistance if necessary. 4. Be able to transfer, with assistance if necessary. The assistance of more than one person is permitted. 5. Be capable of taking medication, by either self-administration, assistance with self-administration, or administration of medication.	A 007		

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A 007	Continued From page 1 a. If the resident needs assistance with self-administration of medication, the facility must inform the resident of the professional qualifications of facility staff who will be providing this assistance. If unlicensed staff will be providing assistance with self-administration of medication, the facility must obtain written informed consent from the resident or the resident's surrogate, guardian, or attorney-in-fact. b. The facility may accept a resident who requires the administration of medication if the facility exploys a nurse who will provide this service or the resident, or the resident's legal representative, designee, surrogate, guardian, or attorney-in-fact, contracts with a third party licensed to provide this service to the resident. 6. Not have any special dietary needs that cannot be met by the facility. 7. Not be a danger to self or others as determined by a physician, or mental health practitioner licensed under chapter 490 or 491, F.S. 8. Not require 24-hour licensed professional mental health treatment. 9. Not be bedridden. 10. Not have any [illegible] or 4 , [illegible] . A resident requiring care of a [illegible] may be admitted provided that: a. The resident either: (I) Resides in a standard or limited nursing services licensed facility and contracts directly with a licensed home health agency or a nurse to provide care; or (II) Resides in a limited nursing services licensed facility and care is provided by the facility pursuant to a plan of care issued by a health care provider; b. The condition is documented in the resident's record and admission and discharge logs; and,	A 007		

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A 007	Continued From page 2 c. If the resident's condition fails to improve within 30 days as documented by a health care provider, the resident must be discharged from the facility. 11. Residents admitted to standard, limited nursing services, or limited mental health licensed facilities may not require any of the following nursing services: a. [illegible] airway management of any kind, except that of continuous positive airway pressure may be provided through the use of a CPAP or bipap machine; b. Assistance with [illegible], c. Monitoring of [illegible] gases, d. Management of post-surgical drainage tubes and [illegible] vacuum devices; e. The administration of [illegible] products in the facility; or f. Treatment of surgical [illegible] or [illegible], unless the surgical [illegible] or [illegible] and the underlying condition have been stabilized and a plan of care has been developed. The plan of care must be maintained in the resident's record. 12. In addition to the nursing services listed above, residents admitted to facilities holding only standard and/or limited mental health licenses may not require any of the following nursing services: a. [illegible] and [illegible] performed in the facility; b. [illegible] performed in the facility. 13. Not require 24-hour nursing supervision. 14. Not require skilled rehabilitative services as described in rule 59G-4.290, F.A.C. 15. Be appropriate for admission to the facility as determined by the facility administrator. The administrator must base the determination on: a. An assessment of the strengths, needs, and preferences of the individual;	A 007		

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A 007	Continued From page 3 b. The medical examination report required by section 429.26, F.S., and subsection (2) of this rule, if available; c. The facility's admission policy and the services the facility is prepared to provide or arrange in order to meet resident needs. Such services may not exceed the scope of the facility's license unless specified elsewhere in this rule; and, d. The ability of the facility to meet the uniform fire safety standards for assisted living facilities established in rule chapter 69A-40, F.A.C. (b) A resident who otherwise meets the admission criteria for residency in a standard licensed facility, but who requires assistance with the administration and regulation of portable ,, or assistance with routine , care of site , placement, may be admitted to a facility with a standard license as long as the facility has a nurse on staff or under contract to provide the assistance or to provide training to the resident on how to perform these functions themselves. (c) Nursing staff may not provide training to unlicensed persons, as defined in section 429.256(1)(b), F.S., to perform skilled nursing services, and may not delegate the nursing services described in this section to certified nursing assistants or unlicensed persons. This provision does not restrict a resident or a resident's representative from , with a licensed third party to provide the assistance if the facility is agreeable to such an arrangement and the resident otherwise meets the criteria for admission and continued residency in a facility with a standard license. (d) An individual enrolled in and receiving hospice services may be admitted to an assisted living facility as long as the individual otherwise meets resident admission criteria.	A 007		

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A 007	Continued From page 4 (e) Resident admission criteria for facilities holding an extended congregate care license are described in rule 58A-5.030, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and record review, the facility failed to ensure that one out of nine sampled residents met the admission criteria (#7). Findings included: On at 7:35 AM, Resident #7 sat on recliner chair in the family room. Review of Resident #7's record revealed that admission date to the facility was on . There was no health assessment completed. Review of hospice record for Resident #7 included a plan of care which showed that the resident started receiving hospice services on . Active orders on showed that the resident needed complete bed bath. Starting on , the record showed that the resident needed to be turned and reposition every two hours when in bed and hourly when in chair. The record further showed that the resident had functional limits of / , endurance, ambulation, and , , , with minimal exertion. He was permitted to transfer from bed to chair and was forgetful and disoriented. Class III	A 007		
A 031 SS=D	58A-5.0182(7) FAC 429.255(1)(b). FS Resident Care - Third Party Services	A 031		

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A 031	Continued From page 5 58A-5.0182 (7) 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) 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.	A 031		

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A 031	Continued From page 6 429.255(1)(b) All staff in facilities licensed under this part shall exercise their professional responsibility to observe residents, to document observations on the appropriate resident ' s record, and to report the observations to the resident ' s physician. However, the owner or administrator of the facility shall be responsible for determining that the resident receiving services is appropriate for residence in the facility. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to coordinate with third party provider to provide the receipt of care and services to meet the resident's needs for one (#4) out of nine sampled residents. Findings included: On at 7:35 AM, Resident #4 sat on recliner chair in the family room. On . . . . . at 9:10 AM, Staff G revealed that none of the residents received home health agency services, none received . . . , none received care. On further interview at 9:13 AM, he revealed that the doctor wanted home health services for Resident #4. Review of Resident #4's record revealed that his admission date to the facility was on . . . . . . The progress notes on record showed that on . . . . . when Primary Care Physician (PCP) checked the resident, he had a small skin on the left . . . . The doctor left a doctor order for Home Health Care (HHC) and one for the podiatry for choosing one services or the other one. On at 7:03 AM, the podiatry was at	A 031		

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A 031	Continued From page 7 the facility and checked the resident's . . . She did not have an opening or nothing but he sent an order to the home health. There was a folder with a home health agency name printed in the front of the page and Resident #4's name handwritten. There was a doctor order by PCP on for HHC skill nursing . . . care, evaluation and treatment of cream to left heel every 12 hours. There was a note (communication log) completed on during the sign up. There was no documentation about the home health services received from to . Class III	A 031		
A 160 SS=D	58A-5.024(1) FAC Records - Facility 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	A 160		

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A 160	Continued From page 8 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 58A-5.025, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in Rule 58A-5.026, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in Rule 58A-5.021, F.A.C.; (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 58A-5.021, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 58A-5.0181, 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 58A-5.0182, F.A.C. (j) All food service records required in Rule	A 160		

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A 160	Continued From page 9 58A-5.020, 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 429.41, F.S., and Rule Chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to document a clear reason for discharge and identification of the address to which the resident was discharged on the log for two out of nine sampled residents (#1 and #6). The facility failed to identified the facility from which the resident was admitted for two out of nine sampled resident (#7 and #8). The facility failed to have a notification indicating that the resident was admitted with special services for	A 160		

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A 160	Continued From page 10 one out of nine sampled residents (#7). The facility failed to have the correct discharge date, reason for discharge and identification of the facility to which the resident was discharged for one out of nine sampled residents (#2). Findings included: On . . . . . at 7:35 AM, Residents #8 and #7 sat on recliner chairs in the family room. Review of the admission and discharge log revealed that Resident #1's admission date was on . The resident's discharge date from the facility was on . . . . and the reason's for discharge was owner's decision to the resident's daughter house. Review of the admission and discharge log revealed that Resident #6's admission date was on . . . . . The resident's discharge date from the facility was on and the reason's for discharge was owner and family's decision to the resident's son house. Review of the admission and discharge log revealed that Resident #7's admission date was on from "another alf" (Assisted Living Facility). The record did not indicate that the resident received special services. Review of Resident #7's hospice record showed that he started receiving hospice services on . Review of the admission and discharge log revealed that Resident #8's admission date was on from "another facility". Review of the admission and discharge log	A 160		

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A 160	Continued From page 11 revealed that Resident #2's admission date was on . The resident's discharge date from the facility was on . The reason for discharge showed "Hospital hospice" and place to which discharged or transferred showed "fallecio" ( ). On at 9:45 AM, Staff C revealed that Resident #2 under hospice services on at the hospital. At 9:47 AM, she added that date was a mistake. Class III	A 160		
A 162 SS=D	58A-5.024(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 health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in Rule 58A-5.0181, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or	A 162		

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A 162	Continued From page 12 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 58A-5.020, F.A.C., if applicable. (e) The resident care record described in paragraph 58A-5.0182(1)(e), 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. (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 58A-5.0181, 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 58A-5.0185, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 58A-5.025, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an . . . recipient, a copy of	A 162		

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A 162	Continued From page 13 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 58A-5.0181, 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 the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement; 2. The resident demographic data required in this paragraph; 3. The health assessment described in Rule 58A-5.0181, F.A.C.; 4. The resident's contract described in Rule 58A-5.025, F.A.C.; and 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident	A 162		

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	AL11969286	A. BUILDING: _____ B. WING _____	09/05/2019

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A 162	Continued From page 14 participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have a written doctor's order indicating that a physician discontinued a medication for one out of nine sampled residents (#3). The facility failed to obtain a health assessment that reflected the resident's new diet and medical diagnoses for one out of nine sampled residents (#3). The facility failed to initiate a [redacted] record on admission for two out of nine sampled residents (#7 and #8). The facility failed to have a complete agreement that included the rate for one out of nine sampled residents (#8). The facility failed to maintain on the premises that resident demographic sheet for two out of nine sampled resident (#8 and #9). The facility failed to have a complete health assessment for two out of nine sampled residents (#4 and #5). Findings included: 1. Review of Resident #3's record revealed that his admission date to the facility was on [redacted]. There were two health assessments one of them	A 162		

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A 162	Continued From page 15 completed on [illegible] and one on [illegible]. Both assessments included as part of the medical history and diagnoses. Review of Resident #3's Medication Observation Records showed that he took one tablet of [illegible] 500 mg [illegible] daily from [illegible] to [illegible]. There was no documentation in the resident's record for discontinuing the [illegible]. 2. Review of Resident #3's record revealed that primary care physician completed the health assessment (AHCA form 1823) completed on [illegible]. It indicated that the resident had regular diet and special precautions for [illegible] and medication supervision. The resident had medical history and diagnoses of [illegible] and [illegible]. Review of Resident #3's hospice record showed the enrollment date to the services on [illegible] with the primary diagnosis of [illegible]'s [illegible], unspecified. The resident also had the diagnoses of [illegible] and unspecified [illegible] not due to a substance or known. The resident had [illegible] precaution, [illegible] precaution, and [illegible] safety precautions. The doctor from hospice ordered on [illegible] at 2 liters per minutes as needed [illegible], full side rails, diet of puree, thick liquids to honey consistency, and to crush medications/open capsules. 3. Review of Resident #7's record revealed that admission date to the facility was on [illegible]. There was no health assessment completed but the hospice record for Resident #7 included a plan of care which showed that the resident	A 162		

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A 162	Continued From page 16 started receiving hospice services on . . . . . . The active orders on showed that the resident needed complete bed bath. Starting on , the resident needed to be turned and reposition every two hours when in bed and hourly when in chair. The resident had functional limits of . . . . /. . . . . , endurance, ambulation, and , , with minimal exertion. He was permitted transfer from bed to chair and was forgetful and disoriented. There was not a record initiated on the admission for Resident #7. 4. Review of Resident #8's record showed that there was no demographic sheet. The resident agreement with the facility was signed on but it did not include the rate charged by the facility. There was a blank informed consent to assistance with self-administration with medication by unlicensed staff. There was not a record initiated on the admission for Resident #8. Review of the admission and discharge log showed that Resident #8's admission date to the facility was on . . . . . . Review of Resident #8's MORs showed that he took medications in the facility and the staff helped him due to they initialed the MORs. On . . . . . at 8:35 AM, Staff G revealed that Resident #8's daughter did not come to the facility to sign the consent of assistance with medication. At 8:41 AM, he added that the daughter brought the resident and did not give any information for the demographic sheet. On at 9:58 AM, Staff C revealed that	A 162		

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A 162	Continued From page 17 she had the contract signed and the facility had 30 days from the day of admission for obtaining the rest of the documents. On further interview at 10:16 AM, Staff C revealed that Resident #8's rate was of $1,300 from the program and $771 from the check. His demographic sheet was not completed yet but she had the resident's family phone number in her cellphone and the staff too. The resident received assistance taking his medications but the facility did not have the signed consent yet. The resident . at the time of admission. On at 10:34 AM, observed Staff C documenting Resident #8's in the log. Review of Resident #9's demographic sheet showed that the resident had the last name as the first name too. The informed consent to assistance with self-administration of medication by unlicensed personnel signed by the resident on showed that the resident's first name and last name were different. The Medication Observation Records showed the resident's first name and last name were different. 5. Review of Resident #4's record revealed that the admission date was on . There was a health assessment on record and it missed the date of examination. Review of Resident #5's records revealed that the admission date was on . The health assessment (AHCA form 1823) completed on showed that the resident had medical history and diagnoses of unspecified D deficiency, "D/M" ( ).	A 162		

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A 162	Continued From page 18 The sections showing the help needed with activities of daily living had the box for self-care section on blank. There was a note in Resident #5's record (looked like from the doctor). It showed the resident's name and that she had diagnoses of deficiency of other specified B group , unspecified , unspecified D deficiency, primary of , other of , nervous system, unsteadiness on , dependence on other enabling machines and devices, essential (primary) , major (single episode, moderate), Class III	A 162		

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A 000	Initial Comments A complaint investigation (complaint numbers 2019013341 and 2019012232) was conducted at Jean Carlos Alf Inc. on . Deficiencies were identified at the time of the survey.	A 000		
A 007 SS=D	429.26(11) FS; 58A-5.0181(1) FAC Admissions - Criteria 429.26 (11) No resident who requires 24-hour nursing supervision, except for a resident who is an enrolled hospice patient pursuant to part of chapter 400, shall be retained in a facility licensed under this part. 58A-5.0181 (1) ADMISSION CRITERIA. (a) An individual must meet the following minimum criteria in order to be admitted to a facility holding a standard, limited nursing services, or limited mental health license: 1. Be at least 2. Be free from signs and symptoms of any communicable that is likely to be transmitted to other residents or staff. An individual who has ( ) may be admitted to a facility, provided that the individual would otherwise be eligible for admission according to this rule. 3. Be able to perform the activities of daily living, with supervision or assistance if necessary. 4. Be able to transfer, with assistance if necessary. The assistance of more than one person is permitted. 5. Be capable of taking medication, by either self-administration, assistance with self-administration, or administration of medication.	A 007		

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A 007	Continued From page 1 a. If the resident needs assistance with self-administration of medication, the facility must inform the resident of the professional qualifications of facility staff who will be providing this assistance. If unlicensed staff will be providing assistance with self-administration of medication, the facility must obtain written informed consent from the resident or the resident's surrogate, guardian, or attorney-in-fact. b. The facility may accept a resident who requires the administration of medication if the facility exploys a nurse who will provide this service or the resident, or the resident's legal representative, designee, surrogate, guardian, or attorney-in-fact, contracts with a third party licensed to provide this service to the resident. 6. Not have any special dietary needs that cannot be met by the facility. 7. Not be a danger to self or others as determined by a physician, or mental health practitioner licensed under chapter 490 or 491, F.S. 8. Not require 24-hour licensed professional mental health treatment. 9. Not be bedridden. 10. Not have any [illegible] or 4 , [illegible] . A resident requiring care of a [illegible] may be admitted provided that: a. The resident either: (I) Resides in a standard or limited nursing services licensed facility and contracts directly with a licensed home health agency or a nurse to provide care; or (II) Resides in a limited nursing services licensed facility and care is provided by the facility pursuant to a plan of care issued by a health care provider; b. The condition is documented in the resident's record and admission and discharge logs; and,	A 007		

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A 007	Continued From page 2 c. If the resident's condition fails to improve within 30 days as documented by a health care provider, the resident must be discharged from the facility. 11. Residents admitted to standard, limited nursing services, or limited mental health licensed facilities may not require any of the following nursing services: a. [illegible] airway management of any kind, except that of continuous positive airway pressure may be provided through the use of a CPAP or bipap machine; b. Assistance with [illegible], c. Monitoring of [illegible] gases, d. Management of post-surgical drainage tubes and [illegible] vacuum devices; e. The administration of [illegible] products in the facility; or f. Treatment of surgical [illegible] or [illegible], unless the surgical [illegible] or [illegible] and the underlying condition have been stabilized and a plan of care has been developed. The plan of care must be maintained in the resident's record. 12. In addition to the nursing services listed above, residents admitted to facilities holding only standard and/or limited mental health licenses may not require any of the following nursing services: a. [illegible] and [illegible] performed in the facility; b. [illegible] performed in the facility. 13. Not require 24-hour nursing supervision. 14. Not require skilled rehabilitative services as described in rule 59G-4.290, F.A.C. 15. Be appropriate for admission to the facility as determined by the facility administrator. The administrator must base the determination on: a. An assessment of the strengths, needs, and preferences of the individual;	A 007		

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A 007	Continued From page 3 b. The medical examination report required by section 429.26, F.S., and subsection (2) of this rule, if available; c. The facility's admission policy and the services the facility is prepared to provide or arrange in order to meet resident needs. Such services may not exceed the scope of the facility's license unless specified elsewhere in this rule; and, d. The ability of the facility to meet the uniform fire safety standards for assisted living facilities established in rule chapter 69A-40, F.A.C. (b) A resident who otherwise meets the admission criteria for residency in a standard licensed facility, but who requires assistance with the administration and regulation of portable ,, or assistance with routine , care of site , placement, may be admitted to a facility with a standard license as long as the facility has a nurse on staff or under contract to provide the assistance or to provide training to the resident on how to perform these functions themselves. (c) Nursing staff may not provide training to unlicensed persons, as defined in section 429.256(1)(b), F.S., to perform skilled nursing services, and may not delegate the nursing services described in this section to certified nursing assistants or unlicensed persons. This provision does not restrict a resident or a resident's representative from , with a licensed third party to provide the assistance if the facility is agreeable to such an arrangement and the resident otherwise meets the criteria for admission and continued residency in a facility with a standard license. (d) An individual enrolled in and receiving hospice services may be admitted to an assisted living facility as long as the individual otherwise meets resident admission criteria.	A 007		

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A 007	Continued From page 4 (e) Resident admission criteria for facilities holding an extended congregate care license are described in rule 58A-5.030, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and record review, the facility failed to ensure that one out of nine sampled residents met the admission criteria (#7). Findings included: On at 7:35 AM, Resident #7 sat on recliner chair in the family room. Review of Resident #7's record revealed that admission date to the facility was on . There was no health assessment completed. Review of hospice record for Resident #7 included a plan of care which showed that the resident started receiving hospice services on . Active orders on showed that the resident needed complete bed bath. Starting on , the record showed that the resident needed to be turned and reposition every two hours when in bed and hourly when in chair. The record further showed that the resident had functional limits of / , endurance, ambulation, and , , , with minimal exertion. He was permitted to transfer from bed to chair and was forgetful and disoriented. Class III	A 007		
A 031 SS=D	58A-5.0182(7) FAC 429.255(1)(b). FS Resident Care - Third Party Services	A 031		

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A 031	Continued From page 5 58A-5.0182 (7) 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) 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.	A 031		

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A 031	Continued From page 6 429.255(1)(b) All staff in facilities licensed under this part shall exercise their professional responsibility to observe residents, to document observations on the appropriate resident ' s record, and to report the observations to the resident ' s physician. However, the owner or administrator of the facility shall be responsible for determining that the resident receiving services is appropriate for residence in the facility. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to coordinate with third party provider to provide the receipt of care and services to meet the resident's needs for one (#4) out of nine sampled residents. Findings included: On at 7:35 AM, Resident #4 sat on recliner chair in the family room. On . . . . . at 9:10 AM, Staff G revealed that none of the residents received home health agency services, none received . . . , none received care. On further interview at 9:13 AM, he revealed that the doctor wanted home health services for Resident #4. Review of Resident #4's record revealed that his admission date to the facility was on . . . . . . The progress notes on record showed that on . . . . . when Primary Care Physician (PCP) checked the resident, he had a small skin on the left . . . . The doctor left a doctor order for Home Health Care (HHC) and one for the podiatry for choosing one services or the other one. On at 7:03 AM, the podiatry was at	A 031		

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A 031	Continued From page 7 the facility and checked the resident's . . . She did not have an opening or nothing but he sent an order to the home health. There was a folder with a home health agency name printed in the front of the page and Resident #4's name handwritten. There was a doctor order by PCP on for HHC skill nursing . . . care, evaluation and treatment of cream to left heel every 12 hours. There was a note (communication log) completed on during the sign up. There was no documentation about the home health services received from to . Class III	A 031		
A 160 SS=D	58A-5.024(1) FAC Records - Facility 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	A 160		

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A 160	Continued From page 8 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 58A-5.025, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in Rule 58A-5.026, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in Rule 58A-5.021, F.A.C.; (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 58A-5.021, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 58A-5.0181, 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 58A-5.0182, F.A.C. (j) All food service records required in Rule	A 160		

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	AL11969286	A. BUILDING: _____ B. WING _____	09/05/2019

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A 160	Continued From page 9 58A-5.020, 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 429.41, F.S., and Rule Chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to document a clear reason for discharge and identification of the address to which the resident was discharged on the log for two out of nine sampled residents (#1 and #6). The facility failed to identified the facility from which the resident was admitted for two out of nine sampled resident (#7 and #8). The facility failed to have a notification indicating that the resident was admitted with special services for	A 160		

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A 160	Continued From page 10 one out of nine sampled residents (#7). The facility failed to have the correct discharge date, reason for discharge and identification of the facility to which the resident was discharged for one out of nine sampled residents (#2). Findings included: On . . . . . at 7:35 AM, Residents #8 and #7 sat on recliner chairs in the family room. Review of the admission and discharge log revealed that Resident #1's admission date was on . The resident's discharge date from the facility was on . . . . and the reason's for discharge was owner's decision to the resident's daughter house. Review of the admission and discharge log revealed that Resident #6's admission date was on . . . . . The resident's discharge date from the facility was on and the reason's for discharge was owner and family's decision to the resident's son house. Review of the admission and discharge log revealed that Resident #7's admission date was on from "another alf" (Assisted Living Facility). The record did not indicate that the resident received special services. Review of Resident #7's hospice record showed that he started receiving hospice services on . Review of the admission and discharge log revealed that Resident #8's admission date was on from "another facility". Review of the admission and discharge log	A 160		

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A 160	Continued From page 11 revealed that Resident #2's admission date was on . The resident's discharge date from the facility was on . The reason for discharge showed "Hospital hospice" and place to which discharged or transferred showed "fallecio" ( ). On at 9:45 AM, Staff C revealed that Resident #2 under hospice services on at the hospital. At 9:47 AM, she added that date was a mistake. Class III	A 160		
A 162 SS=D	58A-5.024(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 health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in Rule 58A-5.0181, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or	A 162		

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A 162	Continued From page 12 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 58A-5.020, F.A.C., if applicable. (e) The resident care record described in paragraph 58A-5.0182(1)(e), 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. (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 58A-5.0181, 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 58A-5.0185, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 58A-5.025, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an . . . recipient, a copy of	A 162		

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A 162	Continued From page 13 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 58A-5.0181, 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 the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement; 2. The resident demographic data required in this paragraph; 3. The health assessment described in Rule 58A-5.0181, F.A.C.; 4. The resident's contract described in Rule 58A-5.025, F.A.C.; and 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident	A 162		

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A 162	Continued From page 14 participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have a written doctor's order indicating that a physician discontinued a medication for one out of nine sampled residents (#3). The facility failed to obtain a health assessment that reflected the resident's new diet and medical diagnoses for one out of nine sampled residents (#3). The facility failed to initiate a [redacted] record on admission for two out of nine sampled residents (#7 and #8). The facility failed to have a complete agreement that included the rate for one out of nine sampled residents (#8). The facility failed to maintain on the premises that resident demographic sheet for two out of nine sampled resident (#8 and #9). The facility failed to have a complete health assessment for two out of nine sampled residents (#4 and #5). Findings included: 1. Review of Resident #3's record revealed that his admission date to the facility was on [redacted]. There were two health assessments one of them	A 162		

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A 162	Continued From page 15 completed on [illegible] and one on [illegible]. Both assessments included as part of the medical history and diagnoses. Review of Resident #3's Medication Observation Records showed that he took one tablet of [illegible] 500 mg [illegible] daily from [illegible] to [illegible]. There was no documentation in the resident's record for discontinuing the [illegible]. 2. Review of Resident #3's record revealed that primary care physician completed the health assessment (AHCA form 1823) completed on [illegible]. It indicated that the resident had regular diet and special precautions for [illegible] and medication supervision. The resident had medical history and diagnoses of [illegible] and [illegible]. Review of Resident #3's hospice record showed the enrollment date to the services on [illegible] with the primary diagnosis of [illegible]'s [illegible], unspecified. The resident also had the diagnoses of [illegible] and unspecified [illegible] not due to a substance or known. The resident had [illegible] precaution, [illegible] precaution, and [illegible] safety precautions. The doctor from hospice ordered on [illegible] at 2 liters per minutes as needed [illegible], full side rails, diet of puree, thick liquids to honey consistency, and to crush medications/open capsules. 3. Review of Resident #7's record revealed that admission date to the facility was on [illegible]. There was no health assessment completed but the hospice record for Resident #7 included a plan of care which showed that the resident	A 162		

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A 162	Continued From page 16 started receiving hospice services on . . . . . . The active orders on showed that the resident needed complete bed bath. Starting on , the resident needed to be turned and reposition every two hours when in bed and hourly when in chair. The resident had functional limits of . . . . /. . . . . , endurance, ambulation, and , , with minimal exertion. He was permitted transfer from bed to chair and was forgetful and disoriented. There was not a record initiated on the admission for Resident #7. 4. Review of Resident #8's record showed that there was no demographic sheet. The resident agreement with the facility was signed on but it did not include the rate charged by the facility. There was a blank informed consent to assistance with self-administration with medication by unlicensed staff. There was not a record initiated on the admission for Resident #8. Review of the admission and discharge log showed that Resident #8's admission date to the facility was on . . . . . . Review of Resident #8's MORs showed that he took medications in the facility and the staff helped him due to they initialed the MORs. On . . . . . at 8:35 AM, Staff G revealed that Resident #8's daughter did not come to the facility to sign the consent of assistance with medication. At 8:41 AM, he added that the daughter brought the resident and did not give any information for the demographic sheet. On at 9:58 AM, Staff C revealed that	A 162		

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A 162	Continued From page 17 she had the contract signed and the facility had 30 days from the day of admission for obtaining the rest of the documents. On further interview at 10:16 AM, Staff C revealed that Resident #8's rate was of $1,300 from the program and $771 from the check. His demographic sheet was not completed yet but she had the resident's family phone number in her cellphone and the staff too. The resident received assistance taking his medications but the facility did not have the signed consent yet. The resident . at the time of admission. On at 10:34 AM, observed Staff C documenting Resident #8's in the log. Review of Resident #9's demographic sheet showed that the resident had the last name as the first name too. The informed consent to assistance with self-administration of medication by unlicensed personnel signed by the resident on showed that the resident's first name and last name were different. The Medication Observation Records showed the resident's first name and last name were different. 5. Review of Resident #4's record revealed that the admission date was on . There was a health assessment on record and it missed the date of examination. Review of Resident #5's records revealed that the admission date was on . The health assessment (AHCA form 1823) completed on showed that the resident had medical history and diagnoses of unspecified D deficiency, "D/M" ( ).	A 162		

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A 162	Continued From page 18 The sections showing the help needed with activities of daily living had the box for self-care section on blank. There was a note in Resident #5's record (looked like from the doctor). It showed the resident's name and that she had diagnoses of deficiency of other specified B group , unspecified , unspecified D deficiency, primary of , other of , nervous system, unsteadiness on , dependence on other enabling machines and devices, essential (primary) , major (single episode, moderate), Class III	A 162		