

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966622	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/16/2020
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GOLDEN AGE SENIORS OF SUNRISE

**9811 NW 31ST PLACE
SUNRISE, FL 33351**

(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 survey was conducted on 01/16/2020 at Golden Age Seniors of Sunrise, Inc. The facility had deficiencies at the time of the survey.	A 000		
A 010 SS=D	429.26(.&9) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination shall be based upon an assessment of the strengths, needs, and preferences of the resident, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (2) A physician, physician assistant, or nurse practitioner who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interest in the facility. (9) A . . . , ill resident who no longer meets the criteria for continued residency may remain in	A 010		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A 010	Continued From page 1 the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident are being met. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 59A-36.002, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days. (b) A resident requiring care of a . . . may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care provider, the resident must be discharged from	A 010			

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A 010	Continued From page 2 the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by:	A 010			

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A 010	Continued From page 3 Based on observation, interview and record review, the facility failed to ensure that they determine the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. They also failed to ensure that the determination shall be based upon an assessment of the strengths, needs, and preferences of the resident, the care and services offered or arranged for by the facility in accordance with facility policy for 2 of 2 sampled resident records reviewed. (Specifically, Resident # 1 and Resident # 4). The findings included: On at 10:00 AM, an observation was made of Resident # 1 and # 2. They were observed sitting in the activity room of the facility. They were non-verbal and did not respond to the interview questions. She was observed thin and frail. On a review of the Florida Health Assessment form (AHCA 1823 form) was conducted. It was revealed that Resident # 1 was admitted into the facility last exam date for the AHCA 1823 form was The Interdisciplinary Care Plan was missing from the file. The date of the hospice admission was unknown. The file was missing any notes regarding any hospice care. It was unclear what services were being provided by Hospice Care. The Hospice Physician certification form was also missing from the file. It was unknown what the Hospice admitting diagnosis were. The last taken by the staff was taken on At this time, the resident It was revealed that the was missing or unknown.	A 010		

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A 010	Continued From page 4 On _____ a review of the AHCA 1823 form was conducted for Resident # 4. Resident # 4. She was admitted on _____. She suffers from the following diagnosis: _____, Major _____, _____, Polytheism, _____, Gaston _____, and Aphasia. She is a _____ adult, suffering from the infirmities of aging. The AHCA exam date was _____. Under the section of Nursing/treatment and services, it shows that the resident receives assistance with medication management and assistance with Activities of Daily Living (ADL's). The section on special precautions was left blank. A review of the Home Health folder revealed that the resident was receiving _____. the AHCA 1823 form nor the progress notes reflect third party services received by the resident. The significant change was not documented on the AHCA 1823 form. Further review of this form revealed that the last _____ was taken on _____. On _____ an interview was conducted with the Manager. She acknowledged the findings and stated she would have the AHCA 1823 forms updated to reflect the accurate information. Class III	A 010		
A 026 SS=D	59A-36.007(2) FAC Resident Care - Social & Leisure Activities (2) SOCIAL AND LEISURE ACTIVITIES. Residents shall be encouraged to participate in social, recreational, educational and other	A 026		

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A 026	Continued From page 5 activities within the facility and the community. (a) The facility must provide an ongoing activities program. The program must provide diversified individual and group activities in keeping with each resident's needs, abilities, and interests. (b) The facility must consult with the residents in selecting, planning, and scheduling activities. The facility must demonstrate residents' participation through one or more of the following methods: resident meetings, committees, a resident council, a monitored suggestion box, group discussions, questionnaires, or any other form of communication appropriate to the size of the facility. (c) Scheduled activities must be available at least 6 days a week for a total of not less than 12 hours per week. Watching television is not an activity for the purpose of meeting the 12 hours per week of scheduled activities unless the television program is a special one-time event of special interest to residents of the facility. A facility whose residents choose to attend day programs conducted at adult day care centers, senior centers, mental health centers, or other day programs may count those attendance hours towards the required 12 hours per week of scheduled activities. An activities calendar must be posted in common areas where residents normally congregate. (d) If residents assist in planning a special activity such as an outing, seasonal festivity, or an excursion, up to 3 hours may be counted toward the required activity time. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure scheduled activities are available at least 6 days a week for a total of not less than 12 hours per week, or 4 of 4 sampled residents observed. (Resident # 1 - # 4).	A 026			

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A 026	Continued From page 6 The findings included: On at 09:50 AM - 04:17 PM, an observation was made of the facility's staff and residents. There was Staff A and the Manager present with four (4) residents present. It was observed that scheduled group activities were not conducted for the day. The calendar read: Card game, Lunch, Group discussion, Dinner time and TV. A review of the activity calendar revealed that the times nor the durations were noted on the activity calendar. It was unknown if the activity calendar contained 12 hours of scheduled activity took place for the week. On at 04:17 PM, an interview was conducted with the Manager. She stated that she was busy with the Surveyor. She stated she couldn't conduct activities. Class III	A 026		
A 032 SS=D	59A-36.007(8) FAC Resident Care - Elopement Standards 59A-36.007 (8) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident	A 032		

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A 032	Continued From page 7 has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2) (a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities,	A 032			

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A 032	Continued From page 8 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to sections 429.41(1)(a)3. and 429.41(1)(l), F.S. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to conduct the required Facility Resident Mock Elopement Drills. The facility also failed to conduct and document resident elopement drills conducted twice per year for all direct care staff and administration. The findings included: On at 09:50 AM, an interview was conducted with the Manager of the facility. She was requested to provide evidence of the 2 mock elopement drills for the year of 2018 and 2019. She did not provide the evidence of in-service mock drills by at 04:17 PM. On at 04:17 PM, an interview was conducted with the Manager. She acknowledged the findings. Class III	A 032			
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF.	A 078			

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A 078	Continued From page 9 (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record,	A 078		

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A 078	Continued From page 10 and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all direct care staff provide evidence of a negative () statement on an annual basis, for 2 of 4 sampled employee records reviewed (Staff A and the Administrator). The findings included: On , a review of the employee personnel records was conducted. It was revealed that the Administrator was hired on . She provides direct resident care occasionally. The last annual statement reviewed was dated on . No	A 078			

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A 078	Continued From page 11 further documentation could be located indicating a current statement. On _____, a review of the employee personnel record was also conducted. It was revealed that Staff A was hired on _____. She provides direct resident care. A review of the _____ statement revealed the last date of _____. No further documentation could be located indicating a current statement. On _____ at 04:17 PM, an interview was conducted with the Manager. She acknowledged the findings. Class III	A 078			
A 080 SS=D	429.52() FS: 59A-36.011(1) FAC Training - Core & Competency Test 429.52 (1) Effective _____, each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (2) Administrators and other assisted living facility staff must meet minimum training and education requirements established by the agency by rule.	A 080			

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A 080	Continued From page 12 This training and education is intended to assist facilities to appropriately respond to the needs of residents, to maintain resident care and facility standards, and to meet licensure requirements. (3) The agency, in conjunction with providers, shall develop a competency test and a minimum required score to indicate successful completion of the training and educational requirements. The required training and education must cover at least the following topics: (a) State law and rules relating to assisted living facilities. (b) Resident rights and identifying and reporting neglect, and (c) Special needs of elderly persons, persons with mental illness, and persons with _____ and how to meet those needs. (d) Nutrition and food service, including acceptable sanitation practices for preparing, storing, and serving food. (e) Medication management, recordkeeping, and proper techniques for assisting residents with self-administered medication. (f) Firesafety requirements, including fire evacuation drill procedures and other emergency procedures. (g) Care of persons with _____'s _____ and related _____. 59A-36.011 (1) ASSISTED LIVING FACILITY CORE TRAINING REQUIREMENTS AND COMPETENCY TEST. (a) The assisted living facility core training requirements established by the department pursuant to section 429.52, F.S., shall consist of a minimum of 26 hours of training plus a competency test. (b) Administrators and managers must	A 080			

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A 080	Continued From page 13 successfully complete the assisted living facility core training requirements within 3 months from the date of becoming a facility administrator or manager. Successful completion of the core training requirements includes passing the competency test. The minimum passing score for the competency test is 75%. Administrators who have attended core training prior to _____ and managers who attended the core training program prior to _____, shall not be required to take the competency test. Administrators licensed as nursing home administrators in accordance with chapter 468, part II, F.S., are exempt from this requirement. (c) Administrators and managers shall participate in 12 hours of continuing education in topics related to assisted living every 2 years. (d) A newly hired administrator or manager who has successfully completed the assisted living facility core training and continuing education requirements, shall not be required to retake the core training. An administrator or manager who has successfully completed the core training but has not maintained the continuing education requirements will be considered a new administrator or manager for the purposes of the core training requirements and must: 1. Retake the assisted living facility core training; and, 2. Retake and pass the competency test. (e) The fees for the competency test shall not exceed \$200.00. The payment for the competency test fee shall be remitted to the entity administering the test. A new fee is due each time the test is taken. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that Administrators and	A 080			

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A 080	Continued From page 14 managers shall participate in 12 hours of continuing education in topics related to assisted living every 2 years (the Administrator). The findings included: On _____, a review of the employee personnel record was conducted. It was revealed that the Administrator was hired on _____. She passed the Competency test on _____. The evidence of the last training certificate was completed in 2015. No further evidence of continuing education could be located indicating compliance with this requirement every two years. The most recent 12 hours of continuous training was due in 2019. On _____, an interview was conducted with the facility Manager. She acknowledged the findings. Class III	A 080		
A 081 SS=D	59A-36.011() FAC Training - Staff In-Service (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by	A 081		

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A 081	Continued From page 15 the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to blood-borne viruses, may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident neglect, and abuse. The facility must use its	A 081		

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A 081	Continued From page 16 prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that staff had received the required in-service trainings within 30 days of hire, for 3 of 4 sampled employee records reviewed (Staff A, B and Staff C). The findings included: a) A review of the employee personnel record for Staff A was conducted. It was revealed that Staff A was hired on . She provides direct	A 081			

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A 081	Continued From page 17 resident care. A review of her employee personnel file revealed that Staff A was missing the following training certificate: ADL and Behavioral Needs Training (3 hours). b) A review of the employee personnel record for Staff B was conducted. It was revealed that Staff B was hired on . She provides direct resident care. A review of the employee personnel file revealed that Staff B was missing the following training certificates: elopement response training (1 hour), Reporting major incidents, reporting adverse incidents, and facility emergency procedures (1 hour). c) A review of the employee personnel record for Staff C was conducted. It was revealed that Staff C is also the Manager of the facility. She was hired on . She provides direct resident care. A review of the employee personnel file revealed that the following training certificate were missing: elopement response training (1 hour). On . at 04:17 PM, an interview was conducted with the Manager. She acknowledged the findings. Class III	A 081			
A 161 SS=B	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all	A 161			

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A 161	Continued From page 18 training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in section 429.174, F.S., and rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the	A 161		

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A 161	Continued From page 19 facility and the staffing agency or contractor as described in rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that a copy of the employment application, with references furnished for 1 of 4 sampled staff employment records reviewed: (Specifically, Staff A). The findings included: On a review of the employment personnel record was conducted. It was revealed that Staff A was hired . She provides direct resident care. A review of the employee personnel file revealed that the employment application was incomplete. The application was not signed or dated. The application did not contain the names and contact information for references on the application. On at 04:17 PM, an interview was conducted with the Administrator. She acknowledged the findings. Class III	A 161		

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CZ814 SS=C	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12(2) Care Provider Background Screening Clearinghouse.- (b) Until such time as the _____ are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic _____ submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; _____; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that an employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days, for 1 of 5 sampled staff records	CZ814		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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CZ814	Continued From page 1 reviewed. (Staff D). The findings included: On, a review of the staff schedule was conducted. It was revealed that there are a total of 5 staff employed in the facility. A review of the Provider Background Screening Clearinghouse was conducted. It was revealed that Staff D was hired on She worked in the facility as a Home Health Aide (HHA). She provided direct care to the residents. On at 04:17 PM, an interview was conducted with the Manager. She stated the Staff had stopped working at the facility a long time ago. She could not provide the exact date. She acknowledged the findings. Unclassified.	CZ814		