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
	AL11965265	A. BUILDING: _____ B. WING _____	01/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING OF BELLEAIR	620 BELLEAIR ROAD CLEARWATER, FL 33756

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A 000	Initial Comments A re-licensure (6 month) survey and a complaint survey (complaint number 2020000805) was conducted at Pacifica Senior Living of Belleair on . . . . . Deficiencies were identified at the time of survey.	A 000		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, including an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer, from where it is stored, and bringing it to the resident. (b) In the presence of the resident, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (h) Using a to perform - level checks.	A 052		

AHCA Form 3020-0001

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

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A 052	Continued From page 1 (i) Assisting with putting on and taking off stockings. (j) Assisting with applying and removing an but not with titrating the prescribed settings. (k) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device. (l) Assisting with measuring vital signs. (m) Assisting with bags. (4) Assistance with self-administration does not include: (a) Mixing, converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of preparations. (e) Irrigations or debriding agents used in the treatment of a skin condition. (f) , , or preparations. (g) Medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a competent resident. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.	A 052		

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A 052	Continued From page 2 (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in section 429.256, F.S. and this rule. (b) In addition to the specifications of section 429.256(3), F.S., assistance with self-administration of medication includes, in the presence of the resident, reading the medication label aloud and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from	A 052		

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A 052	Continued From page 3 facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in section 429.256(4), F.S. 1. As used in section 429.256(4)(g), F.S., the term "competent resident" means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication. 2. As used in section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (g) All trained staff must adhere to the facility's . . . . control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to assist with	A 052		

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A 052	Continued From page 4 self-administration of medications appropriately for one (#12) of three residents sampled. Findings included: During a medication pass observation conducted on . . . . . at 12:48 PM, Staff D, an unlicensed medicaiton techinican, was observed not reading the medication label or removing the medication in the presence of Resident #12. A record review conducted on , revealed Staff D, an unlicensed staff, with a date-of-hire of , had taken a six-hour medication training class on . . . . . . In an interview with Staff D conducted on at 12:58 PM, he confirmed that he popped the pill from the medication card into a cup in the medication room and returned the card to the med cart drawer and then walked the cup out to resident in the common area. Class III	A 052		
A 079 SS=G	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 212 16-25 253 26-35 294 36-45 335	A 079		

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A 079	Continued From page 5	A 079		

46-55 375
56-65 416
66-75 457
76-85 498
86-95 539

For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week.
2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours.
3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility.
4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night.
5. A staff member who has completed courses in First Aid and [illegible]
( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times.
a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement.
b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is

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A 079	Continued From page 6 considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least , must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern	A 079		

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A 079	Continued From page 7 for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the	A 079		

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A 079	Continued From page 8 agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to provide adequate supervision and care for the facility is composed of seven (7) memory care cottages. The facility failed to ensure that a staff member was always physically present in each cottage to assist and supervise the residents and all 73 residents diagnosed with or related at risk and threatened the physical and emotional health and safety of the residents. Findings Included: Record review of the staffing schedule conduced on revealed the following staffing levels for that day: 1. First shift there was no one scheduled to do the medication pass and there were eight direct care staff scheduled, one for each cottage except Cottage #5 which had two staff scheduled for the first shift. 2. Second shift had two medication technicians (med techs) and seven direct care staff, one for each cottage.	A 079		

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A 079	Continued From page 9 3. Third shift had one medication tech and four direct care staff. With seven cottages, this left at least 2 cottages without any staff present. With the current staffing patterns the facility placed the residents at risk by having wither one or no staff to supervise and care for the residents, set up meals and do laundry. Residents diagnosed with or related were left alone for extended periods of time. Further review of the staffing scheduled conducted on revealed the facility was also short staffed on the third shift on with 3 direct care staff and 2 medication techs; with 3 direct care staff and 2 medication techs; with 3 direct care staff and 2 medication techs; with 3 direct care staff and one medication tech; with 5 direct care staff and 2 medication techs; with 5 direct care staff and 2 medication techs. This staffing schedule revealed there were multiple days when multiple cottages had no staff physically present at all times. Observation of the facility on at 9:00AM revealed the facility is made up of seven stand-alone secured cottages which a total of 73 or had related residents divided up among the cottages. Cottage #1 had 12 residents and one staff person; Cottage #2 had 14 residents and one staff person; Cottage #3 had 13 residents and one staff person; Cottage # 4 had 8 residents and one staff person; Cottage #5 had 10 residents and two staff; Cottage #6 had 11 residents and one staff person and Cottage # 7 had 5 residents and one staff person.	A 079		

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A 079	Continued From page 10 A medication pass observation conducted on . . . . . at 9:40AM revealed that the Director of Nursing (DON) passing medications scheduled for 8:00AM. This was out of the two-hour window allowed to pass medications. During an observation conducted on from 12:10PM to 12:30PM, Staff J was observed assisting a resident to the restroom while 10 residents were seated at the dining room table waiting for their plated food to be served to them. At 12:16PM, Staff J returned to the dining room and started passing out the plated food, which had been sitting on the counter uncovered from 12:10PM to 12:16PM. In a family interview conducted on at 9:07AM, family member for Resident #7 stated that he did not think that 1 staff person is enough to take care of 13 residents. In a family interview conducted on . . . . . at 2:05PM, the family member of Resident #8, stated that the staff do not communicate with him about his family member. He stated that there is not staff and that there is only 1 staff in a cottage to take care of the residents. In an interview with the DON at 2:25PM conducted on . . . . . , she stated that Resident #17 and Resident #18 required a 2 person assist. In a family interview conducted on . . . . . at 3:01 PM, with a family member of Resident # 9 he stated that there is only one caregiver in the cottage feeding 11 residents. He had helped serve the food and helped the residents at meals. He stated that here was not enough staff to have	A 079		

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A 079	Continued From page 11 one staff in each building and he does not feel that his family member was safe or received any attention due to not enough staff. In a family interview for Resident #15, conducted via phone on at 12:40PM, she expressed concern that 1 staff person to a cottage with 14 residents seems a lot especially when serving food, helping with showers and getting residents dressed. During a staff interview conducted on at 1:35PM, Staff I, stated that the needs of the residents are not being met when there are only 1 caregiver for 12 residents. Staff I stated "when I am giving a shower, there is no one to see if residents or a family member comes in, or if someone needs to go to the bathroom, they have to wait till I come out. I can be in the shower room anywhere from 20 to 30 minutes." During a staff interview conducted on at 2:08PM, Staff K, stated that she has been working by herself for months and there are residents that require a 2 person assist. "I have to have someone come help me. If they are not available the resident has to wait. When I am giving a shower, the residents are by themselves. There is no one to check if they have or need to go to the bathroom." In a staff interview conducted on at 3:11PM, Staff M stated that she has residents in her cottage that are a two-person transfer and the procedure is to call the float to help. The resident has to wait for the other person to arrive to help and if it takes too long stated she does it herself. "I have asked other co-workers what to do about leaving the residents alone and they told me it is just how it is done." The resident's needs are not	A 079		

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A 079	Continued From page 12 being met. Class II	A 079		
A 090 SS=D	59A-36.011(11) FAC Training - (11) TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding . (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide at least one hour of training in the facility's policy and procedures regarding ( ) within 30 days after employment for 2 (Staff A and C) of 3 direct care staff who were sampled for the training. Findings included: Record review of Staff A on revealed she had been hired on and there was no certificate in her personnel file documenting she had received the training.	A 090		

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A 090	Continued From page 13 Record review of Staff C on . . . . . revealed she had been hired on and there was no certificate in her personnel file documenting she had received the training. Interview with the Community Relations Director on . . . . . at 10: 30 am for verification of the missing training revealed she did not find the certificate of . . . trainings in either Staff A or Staff B's personnel files. Class III	A 090		
A 093 SS=D	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are incorporated by reference and available for review at: http://iom.edu/Activities/Nutrition/SummaryDRIs/~/media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%2014.pdf. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use	A 093		

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	AL11965265	A. BUILDING: _____ B. WING _____	01/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING OF BELLEAIR	620 BELLEAIR ROAD CLEARWATER, FL 33756

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A 093	Continued From page 14 of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style	A 093		

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A 093	Continued From page 15 dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of [illegible] the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on [illegible]. (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has [illegible] with residents to serve, must be on [illegible] at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan	A 093		

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A 093	Continued From page 16 coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain a 3 day supply of emergency nonperishable food items for each resident in the event of a disruption to normal food delivery. Findings Included: During an observation conducted with staff N on . . . . . at 1:43 PM of the 3-day emergency food storage closet, there was an insufficient amount of food stored. In an Interview with staff N on at 1:43 PM, while in the 3 day emergency food storage closet, staff H confirmed there was not enough food in storage to provide each resident 3 nutritious meals a day for 3 days. Staff #H stated there was only a day and a half of food in storage. Staff H further stated they are missing a protein and had no dairy in storage. Class III	A 093		
A 161 SS=D	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 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	A 161		

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A 161	Continued From page 17 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 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	A 161		

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A 161	Continued From page 18 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 record review and interview the facility failed to provide when requested the personnel file for the administrator and the . . . . . and Communicable file for 4 (Staff A, B, C and the Director of Nursing) of 4 direct care staff and the administrator. Additionally, the facility did not have the application for employment completed for 3 (Staff A, B, and the Director of Nursing) of 4 direct care staff. Findings included: Record review on . . . . . of the personnel file for Staff A hired on revealed she did not have any documentation in her file showing she had taken the yearly test and there was no health care provider statement stating she was free of communicable . . in her personnel file. Record review on . . . . . for Staff A revealed she completed only one page of the employment application. There were three pages. Record review on of the personnel file for Staff B hired on . . . . . revealed she did not have any documentation in her file showing she had taken the yearly . . . . . test and there was no health care provider statement stating she was free of communicable . . . . . in her personnel file. Record review on for Staff B revealed she did not have her references which she listed on the employment application reviewed and documented.	A 161		

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A 161	Continued From page 19 Record review on . . . . . of the personnel file for Staff C hired on . revealed she did not have any documentation in her file showing she had taken the yearly test and there was no health care provider statement stating she was free of communicable in her personnel file. Record review on . . . . . of the personnel file for the Director of Nursing revealed she did not have any documentation in her file showing she had taken the yearly test and there was no health care provider statement stating she was free of communicable in her personnel file. Record review on . . . . . for the Director of Nursing showed she did not have a completed employment application. She had not signed the application. When the personnel file was requested for the administrator on . . . . . to review her and Communicable statements. The Community Relation Director stated her file was not available for review. The Community Relations Director also verified on that the and Communicable . . . . . statements were not available for review. Also she verified the applications for employment were not completed for Staff A, B and the Director of Nursing. Class III	A 161		
CZ816 SS=C	408.809(2a-c) 435.05(2) 59A-35.090(2d-3c Background Screening-Compliance Attestation	CZ816		

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CZ816	Continued From page 20 408.809 Background screening; prohibited offenses.- (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's ␣␣␣ to the Federal Bureau of Investigation for a national criminal history record check unless the person's ␣␣␣ are enrolled in the Federal Bureau of Investigation's national retained print ␣␣␣ notification program. If the ␣␣␣ of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit ␣␣␣ electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the ␣␣␣ to the Federal Bureau of Investigation for a national criminal history record check. The ␣␣␣ shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print ␣␣␣ notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person ␣␣␣. Until a specified agency is fully implemented in the clearinghouse created under s. 435.12, the agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within	CZ816		

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CZ816	Continued From page 21 the previous 5 years to meet any provider or professional licensure requirements of the agency, the Department of Health, the Department of Elderly Affairs, the Agency for Persons with , the Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that: (a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section; (b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and (c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency. 435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers: (2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if for any of the disqualifying offenses while employed by the employer. 59A-35.090 Background Screening. (2) Processing Screening Requests, Required Documents and Fees. (d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, , herein incorporated by reference, available at	CZ816		

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CZ816	Continued From page 22 http://www.flrules.org/Gateway/reference.asp?No=Ref-09106, and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Regulations_Forms.shtml. This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if for any disqualifying offense. (e) An administrator or chief financial officer must be screened and qualified prior to to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the report and court disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with section 435.06(3), F.S. (c) The eligibility results of employee screening and the signed Attestation referenced in subsection 59A-35.090(2), F.A.C., must be in the	CZ816		

Agency for Health Care Administration

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CZ816	Continued From page 23 employee's personnel file, maintained by the provider. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have 1 (Staff C) of 3 direct care staff sign the Attestation of Compliance. Every staff must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment and agreeing to inform the employer immediately if for any of the disqualifying offenses while employed by the employer. Findings included: Record review on of Staff C's personnel file revealed the Attestation of Compliance form was not signed. All staff must sign this form. When interviewed on at 1:00 pm, the Community Relations Director verified the Attestation of Compliance form was not signed by Staff C. Unclassified	CZ816		