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
	AL11942793	A. BUILDING: _____ B. WING _____	03/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA MILAGROSA HOME	3341 SW 7 STREET MIAMI, FL 33135

(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 number 2020003292) was conducted at La Milagrosa Home on & . Deficiencies were identified at the time of the survey.	A 000		
A 008 SS=D	429.26(.) FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (4) If possible, each resident shall have been examined by a licensed physician, a licensed physician assistant, or a licensed nurse practitioner within 60 days before admission to the facility. The signed and completed medical examination report shall be submitted to the owner or administrator of the facility who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission and continued stay in the facility. The medical examination report shall become a permanent part of the record of the resident at the facility and shall be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (5) Except as provided in s. 429.07, if a medical examination has not been completed within 60 days before the admission of the resident to the facility, a licensed physician, licensed physician assistant, or licensed nurse practitioner shall examine the resident and complete a medical examination form provided by the agency within 30 days following the admission to the facility to enable the facility owner or administrator to determine the appropriateness of the admission. The medical examination form shall become a	A 008		

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A 008	Continued From page 1	A 008		

permanent part of the record of the resident at the facility and shall be made available to the agency during inspection by the agency or upon request.
(6) Any resident accepted in a facility and placed by the department or the Department of Children and Families shall have been examined by medical personnel within 30 days before placement in the facility. The examination shall include an assessment of the appropriateness of placement in a facility. The findings of this examination shall be recorded on the examination form provided by the agency. The completed form shall accompany the resident and shall be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or [illegible] nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident providing it was completed within 90 days prior to admission to the facility. The applicable department shall provide to the facility administrator any information about the resident that would help the administrator meet his or her responsibilities under subsection (1). Further, department personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The

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A 008	Continued From page 2 applicable department shall advise and assist the facility administrator where the special needs of residents who are recipients of [illegible] require such assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a [illegible]-to-[illegible] medical examination completed by a health care provider as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 calendar days before the individual's admission to a facility pursuant to section 429.26(4), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations, 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living, 3. Any nursing or [illegible] services required by the individual, 4. Any special diet required by the individual, 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication, 6. Whether the individual has signs or symptoms of [illegible] or any other communicable [illegible], which are likely to be transmitted to other residents or staff, 7. A statement on the day of the examination that, in the opinion of the examining health care provider, the individual's needs can be met in an assisted living facility; and, 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care	A 008		

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A 008	Continued From page 3 provider. The medical examination may be conducted by a health care provider licensed under chapter 458, 459 or 464, F.S. (b) A medical examination completed after the resident's admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, [illegible], which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09170. Faxed or electronic copies of the completed form are acceptable. The form must be completed as instructed. 1. Items on the form that have been omitted by the health care provider during the examination may be obtained by the facility either orally or in writing from the health care provider. 2. Omitted information must be documented in the resident's record. Information received orally must include the name of the health care provider, the name of the facility staff recording the information, and the date the information was provided. 3. Electronic documentation may be used in place of completing the section on AHCA Form 1823 referencing Services Offered or Arranged by the Facility for the Resident. The electronic documentation must include all of the elements described in this section of AHCA Form 1823. (c) Any information required by paragraph (a), that is not contained in the medical examination report conducted before the individual's admission to the facility must be obtained by the administrator using AHCA Form 1823 within 30 days after admission. (d) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with	A 008		

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A 008	Continued From page 4 either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of section 429.26, F.S. and this rule. (f) Any orders issued by the health care provider conducting the medical examination for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility may be attached to the health assessment. A health care provider may attach a DH Form 1896, Florida Form, for residents who do not wish to be administered in the case of or (g) 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 the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have resident's health assessment completed within 60 days prior to admission into the facility or 30 days after been admitted in the facility for two out of twelve (Resident #3 and #12)	A 008		

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A 008	Continued From page 5 sampled residents. Finding included: Review of resident records showed that for Resident #3 admitted on and for Resident #2 admitted on , there was no documentation of a health assessment. Interview conducted on at 2:40 PM, Administrator acknowledge that the facility did not have a health assessment for Resident #3 and #12. Class III	A 008		
A 025 SS=J	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident,	A 025		

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A 025	Continued From page 6 including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide care and services and to offer personal supervision appropriate to the needs for one out of twelve (Residents #1) sampled residents. The facility failed to appropriately assess for changes in condition and failed to notify the health care provider when a resident exhibited a significant change for one out of twelve (Resident #1) sampled residents. Findings Included:	A 025		

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A 025	Continued From page 7 1) On at 12:22 PM, Staff C stated she woke up on . . . . . and found facility's front door opened. She checked all the residents and found Resident #1 was not in the facility. She searched for Resident #1 inside and outside the facility. She called the administrator and searched for Resident #1 in the neighborhood. She stated that she did not find him. She said Resident #1 went to the cemetery and felt bad a few months ago. Someone called rescue and he was transferred to the hospital. She stated she worked with Staff G the date of the incident. Staff C stated Staff G was a new staff and did not work in the facility for a long time. She further stated that 'Staff B came in the morning because she did not know that Staff G was working with me and stayed in the facility because we were looking for Resident #1.' On . . . . . at 3:45 PM, Staff F stated that she was not there when Resident #1 went missing, and that Staff C and G were working that day. She said Resident #1 used to go out of the facility to the closest store, and to the cemetery in the past. She stated that she had not let him leave the facility recently because he had memory problems and walked with difficulty. She said that he could not remember where his room or the bathroom were, at times. On at 2:27 PM, Staff B stated Staff C was working alone in the facility when she arrived at 6:00 AM the day of the incident. She said Resident #1 woke up, took his medications and left the facility. She further stated that Resident #1 did not come to eat lunch at 12:00 PM and she contacted the administrator. She said that she did not know who Staff G was, because Staff G was not there when she arrived. She said that the	A 025		

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A 025	Continued From page 8 facility's property gate had a lock all the time. She did not know if the lock was broken at any time. A review of the facility's employee records showed there was no employee file available for review for Staff G, hire date unknown. A review of the background screening clearinghouse database showed that Staff G's hire date was not listed. Record review showed Resident #1 was admitted on . The health assessment dated showed the resident was diagnosed with , , , , had poor vision, memory loss, , debility, was alert and . The physician indicated the resident was independent with ambulation, eating and toileting, and needed supervision with bathing, , grooming and transferring. The physician documented that the resident was not under elopement risk. Adverse Incident report review showed Resident #1 left the facility after having eaten breakfast and taking his morning medications on . The resident did not return, and they started to go to different places that they know he visited and started calling hospitals at 1:00 PM. The resident did not return, and we called the police at 5:33 PM. The fifteen days report documented that the resident was not found. Medication record review showed Resident #1's medications were marked as given on at 7:00 AM. The resident was prescribed , 10 mg (7 AM) (for), , 100 mg (7 PM), , 25 mg (12 PM), , 50 mg (7 PM) (an), , 30 mg (7 PM) (for	A 025		

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A 025	Continued From page 9), 20 mg (7 PM) (for), 20 mg (7 AM) for), 325 mg (7 AM-7 PM) (for) and C-500 mg (7 AM). Review of Resident's #1 medication cards showed that the medications for scheduled at 7:00 AM were missing. On at 9:45 AM Staff F was observed initialing the medication book for resident #10. Review of the medication observation records for Resident #1, 2, 3, 4, 5, 6, 7, 8, 9, and 10 showed that the staff had not initialed the medications as given on for the 7 PM medications and on for the 7 AM medications. On a medication reconciliation confirmed that the medications packs had no tablets in the spaces dated the PM medications and the 7 AM medications dated . On at 9:45 AM, Staff F stated, "I had not the chance yet to initial the sheet." Facility's record review found that only four residents were authorized to go out of the facility (Resident #1, #2, #6 and #12). The residents needed to sign the log before leaving the facility. The rest of the residents can only leave the facility with their family members and or authorized representative. Review of the sign in/out log showed Resident #1 signed the log approximately two years ago, on . The log also showed he signed it on and ; however, the signatures do not match any of his other signatures. The administrator stated the staff	A 025		

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A 025	Continued From page 10 signed the log for the resident sometimes. Observation on [redacted] during the survey showed that Resident #4 and #6 left the facility to go to doctors' [redacted] and did not sign the log. Interview conducted on [redacted] at 10:45 AM, Administrator stated Staff B and C were working the date of the incident. Staff G was not a facility's staff. Staff G was waiting for him in the facility to complete her paperwork because he was in the process to hire her. Resident #1 liked to walk outside the facility. He visited the cemetery and the closest stores every day. He left the facility at 6:15 AM on [redacted]. The staff called me at 5:00 PM because he did not return. We looked for him and called the hospitals. I called the police and filed a missing person report. Resident #1 had facility's information in his wallet with him when he left the facility. In addition, the administrator acknowledge he had not completed a [redacted] assessment for Resident #3. 2) Progress notes documented Resident #1 was walking in the neighborhood and feel [redacted] and weak, a neighbor called rescue for assistance on [redacted]. Rescue assessed him and the resident was transferred to Coral Gables hospital. Rescue passed by the facility and gathered all the information. The resident returned on [redacted] Hospital record review showed that rescue found Resident #1 on the bus stop lying on the ground and [redacted] on [redacted] at 7:28 AM. The resident was transferred to the hospital and diagnosed with [redacted], and [redacted]. The	A 025		

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A 025	Continued From page 11 resident was discharged on . . . . The record document the resident was discharged to the facility and needed to follow up with his primary care physician. Resident's #1 record review found no documentation that Resident #1's primary care physician was contacted after the resident returned from the hospital on . . . . . . Class I	A 025		
A 032 SS=J	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 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,	A 032		

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A 032	Continued From page 12 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, 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:	A 032		

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A 032	Continued From page 13 Based on observation, record review and interview, the facility failed to identify and assess one out of twelve (Resident #1) sampled resident who were at risk for elopement. The facility failed to develop an elopement prevention plan for one out of twelve (Resident #1) sampled residents. Resident #1 . . . . . away from the facility twice, once found . . . . . on the street, and the second time never being found. Findings Included: A review of the facility's elopement policies and procedures showed "Establish a method of assessing residents for risk of . . . . . and eloping at the time of admission and as needed and Develop and implement preventive measures to make sure to stop . . . . . and elopement whenever possible. Facility members will be notified by management (Administrator) within one-half hour of the elopement. The police will be notified as soon as it has determined that the residents is not in the facility and is missing by the administrator." Adverse Incident report review showed Resident #1 left the facility after having eating breakfast and taking his morning medications on . . . . . The resident did not return, and they started to go to different places that they knew he visited and started calling hospitals at 1:00 PM. The resident did not return, and we called the police at 5:33 PM, almost twelve hours after the resident was found to be missing. The fifteen day report documented that the resident was not found. Interview conducted on at 12:22 PM, Staff C stated she woke up on . . . . . and found facility's front door opened. She checked all	A 032		

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	AL11942793	A. BUILDING: _____ B. WING _____	03/02/2020

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A 032	Continued From page 14	A 032		

the residents and found Resident #1 was not in the facility. She searched for Resident #1 inside and outside the facility. She called the administrator and searched for Resident #1 in the neighborhood. She stated that she did not find him. She said Resident #1 went to the cemetery and felt bad a few months ago. Someone called rescue and he was transferred to the hospital. She stated she worked with Staff G the date of the incident. Staff G was a new staff and did not work in the facility for a long time. Staff B came in the morning because she did not know that Staff G was working with me and stayed in the facility because we were looking for Resident #1.

Record review showed Resident #1 was admitted on . The health assessment dated showed the resident was diagnosed with , had poor vision, memory loss, , debility, was alert and . The physician indicated the resident was independent with ambulation, eating and toileting, and needed supervision with bathing, , grooming and transferring. The physician documented that the resident was not under elopement risk.

Interview conducted on at 10:45 AM, Administrator stated Staff B and C were working the date of the incident. Staff G was not a facility's staff. Staff G was waiting for him in the facility to complete her paperwork because he was in the process to hire her. Resident #1 liked to walk outside the facility. He visited the cemetery and the closest stores every day. He left the facility at 6:15 AM on . The staff called me at 5:00 PM because he did not return. We looked for him and called the hospitals. I called the police and filed a missing person report. Resident #1 had facility's information in his wallet with him

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A 032	Continued From page 15 when he left the facility. In addition, the administrator acknowledge he had not completed a [redacted] assessment for Resident #3. However, on [redacted] at 3:45 PM, Staff F stated that she was not there when Resident #1 eloped, but in the past, he used to go out of the facility to the closest store, and to the cemetery. She stated that she had not let him leave the facility recently because he had memory problems and walked with difficulty. She said that he could not remember where his room or the bathroom were, at times. Staff F stated that she was not there when Resident #1 eloped, Staff C and G were working that day. She said Resident #1 used to go out of the facility to the closest store, and to the cemetery in the past. She stated that she had not let him leave the facility recently because he had memory problems and walked with difficulty. She said that he could not remember where his room or the bathroom were, at times. Review of the sign in/out log showed Resident #1 signed the log approximately two years ago, on [redacted]. The log also showed he signed it on [redacted] and [redacted]; however, the signatures did not match any of his other signatures. The administrator stated the staff signed the log for the resident sometimes. Review of the elopement drill log showed the facility conducted an elopement drill on [redacted], and [redacted]. Staff record review showed Staff A, B, C, D, E and F completed the in-service training in regarding the facility's resident elopement response policies and procedures. Staff A received the training on [redacted], Staff B on [redacted], Staff C on [redacted], Staff D on [redacted], Staff E on [redacted] and Staff F on [redacted].	A 032		

Agency for Health Care Administration

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A 032	Continued From page 16 Resident's #1 progress notes also documented that the resident was walking in the neighborhood and felt , and weak, a neighbor called rescue for assistance on . Rescue assessed him and the resident was transferred to Coral Gables hospital. Rescue passed by the ALF and gathered all the information. Hospital record review showed that emergency medical services also found Resident #1 at the bus stop lying on the ground and on at 7:28 AM. The resident was transferred to the hospital and diagnosed with , , , and . The resident was discharged on . The resident returned on . There was no documentation in the resident record that the resident was reassessed for after he incident. 2) Facility's record review found that only four residents were authorized to go out of the facility (Resident #1, #2, #6 and #12). The residents needed to sign the log before leaving the facility. The rest of the residents can only leave the facility with their family members and or authorized representative. Observation on during the survey showed that Resident #4 and #6 left the facility to go to doctors' , and did not sign the "sign in/out log." Resident's record review showed Resident #7 admitted on was diagnosed with by the physician and there was no documentation of the elopement assessment	A 032		

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A 032	Continued From page 17 conducted at the time of the admission. Resident #10 admitted on was diagnosed with by the physician and the elopement assessment conducted on documented the resident was not an elopement risk. Resident #3 was admitted on and there was no documentation of the elopement assessments completed at the time of admission. Class I	A 032		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone	A 054		

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A 054	Continued From page 18 number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on observations, record review and interview the facility failed to ensure the medication log was initialed immediately after medications were given for ten out of ten (Resident #1, 2, 3, 4, 5, 6, 7, 8, 9, and 10) sampled residents. Findings included: On . . . . . at 9:45 AM Staff F was observed initialing the medication book for resident #10. Review of the mediation sheets for Resident #1, 2, 3, 4, 5, 6, 7, 8, 9, and 10 showed that the staff had not initialed the medication observation record (MOR) as given on . . . . . for the 7 PM medications and on for the 7 AM medications. On . . . . . a medication reconciliation confirmed that the medications packs had no tablets in the spaces dated . . . . . the PM medications and the 7 AM medications dated . . . . . . Interview conducted on at 9:45 AM, Staff F stated, "I had not the chance yet to initial	A 054		

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A 054	Continued From page 19 the sheet." Class III	A 054		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . 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	A 078		

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A 078	Continued From page 20 education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility . . . . . 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 record review and interview the facility failed to have negative examination documented annually for one out of four (Staff B) sampled staff. Findings included: Review of staff records showed Staff B hired on	A 078		

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A 078	Continued From page 21 . . . . . had the . . . . . examination documented on and expired on . . . . . . On . . . . . at 3:30 PM the Administrator acknowledged Staff B did not have the updated . . . . . result document in the file. Class III	A 078		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. . . , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance . . . , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, ... , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a	A 162		

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A 162	Continued From page 22 therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C. (f) A [illegible] 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 [illegible] 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 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written 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 [illegible] recipient, a copy of the Department of Children and Families form Alternate Care Certification for [illegible] ( ), CF-ES 1006, [illegible], which is hereby incorporated by reference	A 162		

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A 162	Continued From page 23 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 [illegible] of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's [illegible], 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 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident 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	A 162		

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A 162	Continued From page 24 retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to accept the power of attorney for one out of twelve (Resident #1) sampled residents. Findings included: Review of Resident #1's record showed that there was documentation of a power of attorney done on . Interview conducted on at 3:38 PM, Administrator stated "Resident's #1 power of Attorney was not valid because the the authorized person was a previous facility's employee and did not have any relationship with the resident at present. Class III	A 162		