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
	AL11932616	A. BUILDING: _____ B. WING _____	10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE, INC.	13107 N. 22ND STREET TAMPA, FL 33612

(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: 2020002357), an . . . . Control Visit, and a Generator Monitoring was conducted at Arbor Village on . . . . Deficiencies were identified at the time of survey.	A 000		
A 079 SS=D	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 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	A 079		

AHCA Form 3020-0001

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

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A 079	Continued From page 1 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 , , ( ) 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 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	A 079		

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A 079	Continued From page 2 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 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	A 079		

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A 079	Continued From page 3 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 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 and interview, the Facility failed to provide the minimum required direct care staffing levels. Findings included:	A 079		

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A 079	Continued From page 4 A review of the staffing schedule, conducted on [redacted], revealed that the Facility provided 220-direct care staffing hours for the week of [redacted] through [redacted] for an in-house resident census for twenty-one residents. The minimum required was 253-direct care staffing hours per week. During an interview with the Administrator, conducted on [redacted] at 01:30pm, the Administrator agreed that the Facility did not schedule the minimum direct care staff to meet the required 253-direct care staff hours per week. Class III	A 079		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52(1) (1) 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. (7) Facility staff shall participate in in-service training relevant to their job duties as specified by agency rule of the agency. Topics covered during the preservice orientation are not required to be	A 081		

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A 081	Continued From page 5 repeated during in-service training. A single certificate of completion that covers all required in-service training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (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 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	A 081		

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A 081	Continued From page 6 offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , 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 . The facility must use its 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	A 081		

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A 081	Continued From page 7 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 record review and interview, the Facility failed to provide direct care staff with the required hours with in-service trainings, which included Pre-service Orientation Training, Activities of Daily Living and Behavioral Needs Training, Incident Reporting Training, and Resident Rights and Recognizing [redacted], Neglect, and [redacted] Training for four employees (Administrator and Staff A, B, and C) of four sampled employees. Findings Included: An employee record review for the Administrator, conducted on [redacted], revealed that the Administrator's record contained certificates of training for Activities of Daily Living and Behavioral Needs Training, Incident Reporting Training, and Resident Rights and Recognizing [redacted], Neglect, and [redacted] Training. None of these certificates had the number of hours that the trainings were provided to the Administrator. An employee record review for Staff A, conducted on [redacted], revealed that Staff A's record contained certificates of training for Activities of Daily Living and Behavioral Needs Training and Resident Rights and Recognizing [redacted], Neglect, and [redacted] Training. None of these	A 081		

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A 081	Continued From page 8 certificates had the number of hours that the trainings were provided to Staff A. An employee record review for Staff B, conducted on , revealed that Staff B's record did not contain evidence that the employee had attended a required two-hour Pre-service Orientation Training prior to providing direct care to residents. An employee record review for Staff C, conducted on , revealed that Staff C's record contained certificates of training for Activities of Daily Living and Behavioral Needs Training, Incident Reporting Training, and Resident Rights and Recognizing , Neglect, and , Training. None of these certificates had the number of hours that the trainings were provided to Staff C. During an interview with the Administrator, conducted on at 01:30pm, the Administrator agreed that Staff A and Staff C's training certificates did not include the number of hours of training provided to the employees. The Administrator agree that Staff B's employee record did not have evidence that the employee completed a required two-hours of Pre-service Orientation Training prior to Staff B providing direct care to residents. Class III	A 081		
A 160 SS=D	59A-36.015(1) FAC Records - Facility The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained	A 160		

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A 160	Continued From page 9 in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in rule 59A-36.013, F.A.C.	A 160		

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A 160	Continued From page 10 (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in rule 59A-36.007, F.A.C. (j) All food service records required in rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to section 429.41, F.S., and rule chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to section 381.031, F.S., and chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills.	A 160		

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A 160	Continued From page 11 (p) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the Facility failed to maintain an up-to-date Admission and Discharge with all required admission and discharge data for two Residents (#1 and #6) of two sampled current and former residents. Findings Included: Observations, conducted on throughout survey, revealed that there was no evidence that Resident #1 resided in the Facility. At 10:42am, Resident #6 was observed as clean, groomed, and dressed appropriately. A review of the Admission and Discharge Log, conducted on , revealed that the Admission and Discharge Log was not up to date and did not include discharge data for Resident #1 or admission data for Resident #6. A review of the Facility's resident list, conducted on , revealed that Resident #1 continued listed as an in-house resident and Resident #6 was not listed as an in-house resident. During an interview with Resident #6, conducted on at 10:42am, Resident #6 stated that it was okay living at the Facility.	A 160		

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A 160	Continued From page 12 During an interview with the Administration, conducted on at 01:30pm, the Administrator agreed that the Admission and Discharge Log was not up to date. Class III	A 160		
A 168 SS=D	429.24(3)(a) FS; 429.27(7), FS Resident Refund Policy 429.24 (3)(a) . . . The refund policy shall provide that the resident or responsible party is entitled to a prorated refund based on the daily rate for any unused portion of payment beyond the termination date after all charges, including the cost of damages to the residential unit resulting from circumstances other than normal use, have been paid to the licensee. For the purpose of this paragraph, the termination date shall be the date the unit is vacated by the resident and cleared of all personal belongings. If the amount of belongings does not preclude renting the unit, the facility may clear the unit and charge the resident or his or her estate for moving and storing the items at a rate equal to the actual cost to the facility, not to exceed 20 percent of the regular rate for the unit, provided that 14 days' advance written notification is given. If the resident's possessions are not claimed within 45 days after notification, the facility may dispose of them. The contract shall also specify any other conditions under which claims will be made against the refund due the resident. Except in the case of or a discharge due to medical reasons, the refunds shall be computed in accordance with the notice of relocation requirements specified in the contract. However, a resident may not be required to provide the licensee with more than	A 168		

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A 168	Continued From page 13 30 days' notice of termination. If after a contract is terminated, the facility intends to make a claim against a refund due the resident, the facility shall notify the resident or responsible party in writing of the claim and shall provide said party with a reasonable time period of no less than 14 calendar days to respond. The facility shall provide a refund to the resident or responsible party within 45 days after the transfer, discharge, or of the resident. The agency shall impose a fine upon a facility that fails to comply with the refund provisions of the paragraph, which fine shall be equal to three times the amount due to the resident. One-half of the fine shall be remitted to the resident or his or her estate, and the other half to the Health Care Trust Fund to be used for the purpose specified in s. 429.18. 429.27, FS Property and personal affairs of residents. - (7) In the event of the . . . . of a resident, a licensee shall return all refunds, funds, and property held in trust to the resident's personal representative, if one has been appointed at the time the facility disburses such funds, and, if not, to the resident's spouse or adult next of kin named in a beneficiary designation form provided by the facility to the resident. If the resident has no spouse or adult next of kin or such person cannot be located, funds due the resident shall be placed in an interest-bearing account, and all property held in trust by the facility shall be safeguarded until such time as the funds and property are disbursed pursuant to the Florida Probate Code. Such funds shall be kept separate from the funds and property of the facility and other residents of the facility. If the funds of the resident are not disbursed pursuant to the Florida Probate Code within 2 years after the	A 168		

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	AL11932616	A. BUILDING: _____ B. WING _____	10/26/2020

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A 168	Continued From page 14 resident's [redacted], the funds shall be deposited in the Health Care Trust Fund administered by the agency. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the Facility failed to provide a refund within forty-five days to one Resident (#1) of one sampled resident that was due a refund after discharge from the Facility. Furthermore, the Facility failed to notify a federal agency that the resident no longer resided in the Facility and to stop payments from coming to the Facility in which the Facility continued to deposit those payments in their bank account after the resident no longer resided in the Facility. Findings Included: Observations, conducted on [redacted], revealed that there was no evidence that Resident #1 resided at the Facility. A review of the Admission and Discharge conducted on [redacted], revealed that there was no evidence that Resident #1 had discharged from the Facility. A review of the list of residents, conducted on [redacted], revealed that Resident continued listed as residing in room one. A record review for Resident #1, conducted on [redacted], revealed that Resident #1 was admitted to the Facility on [redacted] and had given a 30-day notice of residency termination with an effective date stated as [redacted]. There were no progress notes, or any other documents found in Resident #1's record after	A 168		

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A 168	Continued From page 15 . . . . . Photographic evidence obtained. A review of the Facility's bank account, conducted on , revealed that the Facility received $720.50 from through each month for Resident #1 from a federal agency. The Facility received $727.00 from through each month for Resident #1 from a federal agency. Resident #1 should have received a prorated refund in the amount of $463.18 for through . Resident #1 or the federal agency should have received a refund in the amount of $1441.00 for through . Resident #1 or the federal agency should have received a refund in the amount of $3635.35 for through . There was no evidence of any checks clearing the bank account as refunds given to Resident #1 or the federal agency. Photographic evidence obtained. A review of the Administrator's employee record, conducted on , revealed a letter dated that stated, "to whom this may concern [Resident #1] is no longer living with us" and "his brother took him on ". The letter was signed by the Administrator. During an interview with the Administrator, conducted on at 01:30pm, the Administrator stated that Resident #1 discharged from the Facility on as the notice of residency termination stated and that Resident #1 took all his belongings with him. The Administrator stated that the letter in his employee record was to the federal agency notifying them that Resident #1 was no longer residing in the Facility. The Administrator was unable to provide evidence that the letter was actually sent to the federal agency. The	A 168		

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A 168	Continued From page 16 Administrator was unable to explain the reason that the letter to the federal agency stated that Resident #1 had discharge from the Facility on when the resident discharged on . . . . . The Administrator provided a copy of check #319 written out to the federal agency in the amount of $727.00. The Administrator was unable to provide evidence that the check had been sent to the federal agency or that the check had cleared the bank account. Photographic evidence obtained. During a telephone interview with Resident #1's mental health case manager, conducted on . . . . . at 03:27pm, the mental health case manager stated that Resident #1 was residing in a nearby boarding house and is not receiving his federal income money. The mental health case manager stated that the Owner of the boarding house was "ready to kick him out on the street because he is not paying his room and board". Class III	A 168		
A 181 SS=D	59A-36.019(2) FAC Emergency Plan Approval (2) EMERGENCY PLAN APPROVAL. The plan must be submitted for review and approval to the local emergency management agency. (a) If the local emergency management agency requires revisions to the emergency management plan, such revisions must be made and the plan resubmitted to the local office within 30 days of receiving notification that the plan must be revised. (b) A new facility as described in Rule 59A-36.014, F.A.C., and facilities whose ownership has been transferred, must submit an emergency management plan within 30 days	A 181		

Agency for Health Care Administration

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A 181	Continued From page 17 after obtaining a license. (c) The facility must review its emergency management plan on an annual basis. Any substantive changes must be submitted to the local emergency agency for review and approval. 1. Changes in the name, address, telephone number, or position of staff listed in the plan are not considered substantive revisions for the purposes of this rule. 2. Changes in the identification of specific staff must be submitted to the local emergency management agency annually as a signed and dated addendum that is not subject to review and approval. (d) The local emergency management agency is the final administrative authority for emergency management plans prepared by assisted living facilities. (e) Any plan approved by the local emergency management agency is considered to have met all the criteria and conditions established in this rule. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to provide proof of an emergency management plan approval by the local County's emergency management office. Findings Included: During an attempt to review the Facility approved emergency management plan, conducted on [redacted], the document was not provided. A review of an email from the local emergency management office, conducted on [redacted] at 02:24pm, revealed that the Facility did not have an approved emergency management plan as	A 181		

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A 181	Continued From page 18 required. The local emergency management employee stated that the Facility had "not ever had an approved plan" and that "their 2018 plan was almost approved, but the Facility failed to pay their invoice for the plan review and the letter was not released to them" and "their 2019 plan was denied twice, and the Facility failed to respond to our communications after that". During an interview with the Administrator, conducted on . . . . . , the Administrator was unable to provide evidence that the Facility had an approved emergency management plan. Class III	A 181		
AL243 SS=D	429.075(1) FS; 59A-36.011(9) FAC LMH - Training 429.075 (1) To obtain a limited mental health license, a facility must hold a standard license as an assisted living facility, must not have any current uncorrected violations, and must ensure that, within 6 months after receiving a limited mental health license, the facility administrator and the staff of the facility who are in direct contact with mental health residents must complete training of no less than 6 hours related to their duties. This designation may be made at the time of initial licensure or relicensure or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with this part, part II of chapter 408, and applicable rules. This training must be provided by or approved by the Department of Children and Families. 59A-36.011	AL243		

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AL243	Continued From page 19 (9) LIMITED MENTAL HEALTH TRAINING. (a) Pursuant to section 429.075, F.S., the administrator, managers and staff, who have direct contact with mental health residents in a licensed limited mental health facility, must receive the following training: 1. A minimum of 6 hours of specialized training in working with individuals with mental health diagnoses. a. The training must be provided or approved by the Department of Children and Families and must be taken within 6 months of the facility's receiving a limited mental health license or within 6 months of employment in a limited mental health facility. b. Training received under this subparagraph may count once for 6 of the 12 hours of continuing education required for administrators and managers pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 2. A minimum of 3 hours of continuing education, which may be provided by the ALF administrator, online, or through distance learning, biennially thereafter in subjects dealing with one or more of the following topics: a. Mental health diagnoses; and, b. Mental health treatment such as: (I) Mental health needs, services, behaviors and appropriate interventions; (II) Resident progress in achieving treatment goals; (III) How to recognize changes in the resident's status or condition that may affect other services received or may require intervention; and, ( ) Crisis services and the . . . . . procedures. 3. For administrators and managers, the continuing education requirement under this subsection will satisfy 3 of the 12 hours of	AL243		

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AL243	Continued From page 20 continuing education required biennially pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 4. Administrators, managers and direct contact staff affected by the continuing education requirement under this subsection shall have up to 6 months after the effective date of this rule to meet the training requirement. (b) Administrators, managers and staff do not have to repeat the initial training should they change employers provided they present a copy of their training certificate to the current employer for retention in the facility's personnel files. They must also ensure that copies of the continuing education training certificates, pursuant to subparagraph (a)2. of this subsection, are retained in their personnel files. This Statute or Rule is not met as evidenced by: Based upon record review and interview, the Facility failed to ensure that all employees completed three hours of continuing education in mental health topics every two years as required for two employees (Staff A and B) of four sampled employees. Findings Included: A record review for Staff A, conducted on [redacted], Staff A did not have evidence that the employee had three hours of continuing education in mental health topics every two years as required. Staff A had an eight-hour Limited Mental Health training on [redacted]. A record review for Staff B, conducted on [redacted], Staff B did not have evidence that the employee had three hours of continuing education in mental health topics every two years	AL243		

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AL243	Continued From page 21 as required. Staff B had an eight-hour Limited Mental Health training on . During an interview with the Administrator, conducted on at 01:30pm, the Administrator agreed that Staff A and B's employee record did not contain evidence that the employees had completed three hours of continuing education for topics in mental health every two years as required. Class III	AL243		