

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                        |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11910844</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/16/2020</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**OAK MANOR**

**3600 OAK MANOR LANE  
LARGO, FL 33774**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 161<br>SS=D            | <p>429.275(2) FS; 59A-36.015(2) FAC Records - Staff</p> <p>429.275</p> <p>(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 licensure or certification is required under this part or rule.</p> <p>59A-36.015</p> <p>(2) STAFF RECORDS.</p> <p>(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:</p> <ol style="list-style-type: none"> <li>1. Documentation of compliance with all staff training and continuing education required by rule 59A-36.011, F.A.C.,</li> <li>2. Copies of all licenses or certifications for all staff providing services that require licensing or certification,</li> <li>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.,</li> <li>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.,</li> <li>5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c),</li> </ol> | A 161               |                                                                                                                          |                          |

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                |                                                                                                                          |                          |                                                        |
|------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11910844</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/16/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAK MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3600 OAK MANOR LANE<br/>LARGO, FL 33774</b>                                  |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 161                                                | <p>Continued From page 1</p> <p>F.A.C.</p> <p>(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.</p> <p>(c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by rule 59A-36.010, F.A.C.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on record review and interview, the facility failed to ensure two of four staff sampled (administrator; Staff D) had completed applications on file.</p> <p>Findings included:</p> <p>Personnel record review during the ... biennial survey found that neither the administrator nor Staff D had an official application available for review.</p> <p>Interview with the director of nursing at 1:20pm on ... provided no clarification for this omission.</p> <p>Class III</p> | A 161                                                                          |                                                                                                                          |                          |                                                        |
| A 181<br>SS=D                                        | <p>59A-36.019(2) FAC Emergency Plan Approval</p> <p>(2) EMERGENCY PLAN APPROVAL. The plan must be submitted for review and approval to the</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | A 181                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                |                                                                                                                          |                          |                                                        |
|------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11910844</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/16/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAK MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3600 OAK MANOR LANE<br/>LARGO, FL 33774</b>                                  |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 181                                                | <p>Continued From page 2</p> <p>local emergency management agency.</p> <p>(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.</p> <p>(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 after obtaining a license.</p> <p>(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.</p> <p>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.</p> <p>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.</p> <p>(d) The local emergency management agency is the final administrative authority for emergency management plans prepared by assisted living facilities.</p> <p>(e) Any plan approved by the local emergency management agency is considered to have met all the criteria and conditions established in this rule.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on record review and interview, the facility failed to have an approved emergency management plan.</p> | A 181                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                |                                                                                                                          |                          |                                                        |
|------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11910844</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/16/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAK MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3600 OAK MANOR LANE<br/>LARGO, FL 33774</b>                                  |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 181                                                | Continued From page 3<br><br>Findings included:<br><br>Review of emergency management documents<br>yielded the following: a)        —a rejection<br>from the County Emergency Management office;<br>b)        —a second rejection from the County;<br>and c): a voicemail sent to the facility's<br>Maintenance Director from a senior staff person<br>at the County Emergency Management office on<br>, indicating that she couldn't approve the<br>facility for 2019-2020.<br><br>Interview with the administrator at 2:40pm on<br>provided no clear explanation why the<br>issue had not been resolved.<br><br>Class III | A 181                                                                          |                                                                                                                          |                          |                                                        |
| A 000                                                | Initial Comments<br><br>A biennial relicensure survey and complaint<br>investigations (number 2020019468 and<br>2020010662) were conducted at Oak Manor<br>Senior Living Community on<br>. Deficiencies were identified at the time of the<br>survey.                                                                                                                                                                                                                                                                                                                                                                       | A 000                                                                          |                                                                                                                          |                          |                                                        |
| A 078<br>SS=D                                        | 59A-36.010(2) FAC Staffing Standards - Staff<br><br>(2) STAFF.<br>(a) Within 30 days after beginning employment,<br>newly hired staff must submit a written statement<br>from a health care provider documenting that the<br>individual does not have any signs or symptoms<br>of communicable        . The examination<br>performed by the health care provider must have<br>been conducted no earlier than 6 months before<br>submission of the statement. Newly hired staff<br>does not include an employee transferring without                                                                                         | A 078                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                |                                                                                                                          |                          |                                                        |
|------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11910844</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/16/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAK MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3600 OAK MANOR LANE<br/>LARGO, FL 33774</b>                                  |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 078                                                | <p>Continued From page 4</p> <p>a break in service from one facility to another when the facility is under the same management or ownership.</p> <p>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 . . . . .</p> <p>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 . . . . .</p> <p>(b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter.</p> <p>(c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C.</p> <p>(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</p> | A 078                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                        |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11910844</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/16/2020</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**OAK MANOR**

**3600 OAK MANOR LANE  
LARGO, FL 33774**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 078                    | <p>Continued From page 5</p> <p>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.</p> <p>(e) For facilities with a licensed capacity of 17 or more residents, the facility must:</p> <ol style="list-style-type: none"> <li>1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and,</li> <li>2. Maintain time sheets for all staff.</li> </ol> <p>(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.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that one of four staff sampled (administrator) had a current ( ) statement available for review, while four of four staff sampled (administrator.; B; C; D) had no formal statement from a health care provider attesting to their freedom from other communicable . . . . .</p> <p>Findings included:</p> <p>Although personnel file review during the . . . . . survey revealed current . . . evaluations for all four staff sampled, further review of these records found no statements from a health care provider attesting to their freedom from other communicable . . . . .</p> <p>Interview with the director of nursing at 1:20pm on . . . . . provided no explanation for this discrepancy.</p> <p>Class III</p> | A 078               |                                                                                                                          |                          |

Agency for Health Care Administration

|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                          |  |                                                        |
|------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11910844</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/16/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAK MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3600 OAK MANOR LANE<br/>LARGO, FL 33774</b>                                  |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 081                                                | Continued From page 6                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | A 081                                                                          |                                                                                                                          |  |                                                        |
| A 081<br>SS=D                                        | <p>429.52(1 &amp; 7) FS; 59A-36.011( ) FAC Training<br/>- Staff In-Service</p> <p>429.52(1)<br/>(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.</p> <p>(7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course.</p> <p>59A-36.011<br/>(2) STAFF PRESERVICE ORIENTATION.<br/>(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).<br/>(b) New staff must complete the preservice orientation prior to interacting with residents.<br/>(c) Once complete, the employee and the facility administrator must sign a statement that the</p> | A 081                                                                          |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                |                                                                                                                          |                          |                                                        |
|------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11910844</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/16/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAK MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3600 OAK MANOR LANE<br/>LARGO, FL 33774</b>                                  |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 081                                                | <p>Continued From page 7</p> <p>employee completed the preservice orientation which must be kept in the employee's personnel record.</p> <p>(d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover:</p> <ol style="list-style-type: none"> <li>1. Resident's rights; and,</li> <li>2. The facility's license type and services offered by the facility.</li> </ol> <p>(3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff:</p> <p>(a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to blood borne pathogens, may be used to meet this requirement.</p> <p>(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:</p> <ol style="list-style-type: none"> <li>1. Reporting adverse incidents.</li> <li>2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation.</li> </ol> <p>(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</p> | A 081                                                                          |                                                                                                                          |                          |                                                        |



Agency for Health Care Administration

|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                |                                                                                                                          |                          |                                                        |
|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11910844</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/16/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAK MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3600 OAK MANOR LANE<br/>LARGO, FL 33774</b>                                  |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 081                                                | <p>Continued From page 8</p> <p>following subjects:</p> <ol style="list-style-type: none"> <li>1. Resident rights in an assisted living facility.</li> <li>2. Recognizing and reporting resident . . . . . neglect, and . . . . . The facility must use its . . . . . prevention policies and procedures when offering this training.</li> </ol> <p>(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:</p> <ol style="list-style-type: none"> <li>1. Resident behavior and needs.</li> <li>2. Providing assistance with the activities of daily living.</li> </ol> <p>(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.</p> <p>(f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment.</p> <ol style="list-style-type: none"> <li>1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures.</li> <li>2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures.</li> </ol> <p>This Statute or Rule is not met as evidenced by:<br/>Based on record review and interview, the facility failed to ensure that three of three caregiver staff sampled (B-D) had taken the 3 hour training in resident behavior &amp; needs and providing</p> | A 081                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                |                                                                                         |                                                                                                                          |                                                        |
|------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11910844</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                  |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/16/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAK MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3600 OAK MANOR LANE<br/>LARGO, FL 33774</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| A 081                                                | Continued From page 9<br><br>assistance with activities of daily living (ADLs)<br>and the 1 hour training in reporting adverse<br>incidents.<br><br>Findings included:<br><br>A personnel record review during the<br>survey found that Staff B, C, and D had no<br>documented evidence verifying they had received<br>the 1 hour training in reporting adverse incidents<br>as well as the 3 hr. training in providing<br>assistance with ADLs and resident behavior and<br>needs. Interview with the director of nursing at<br>1:45pm provided no explanation for this<br>oversight.<br><br>Class III                                                                                                                                                            |                                                                                | A 081                                                                                   |                                                                                                                          |                                                        |
| A 082<br>SS=D                                        | 59A-36.011(4) FAC Training -<br>(4)<br>( ). Pursuant to section<br>381.0035, F.S., all facility employees, with the<br>exception of employees subject to the<br>requirements of section 456.033, F.S., must<br>complete a one-time education course on<br>and , including the topics prescribed in the<br>section 381.0035, F.S. New facility staff must<br>obtain the training within 30 days of employment.<br>Documentation of compliance must be<br>maintained in accordance with subsection (12), of<br>this rule.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview, the facility<br>failed to ensure that two of four staff sampled<br>(administrator; C) had taken the one-time<br>education course on and . |                                                                                | A 082                                                                                   |                                                                                                                          |                                                        |

Agency for Health Care Administration

|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                |                                                                                         |                                                                                                                          |                                                        |
|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11910844</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                  |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/16/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAK MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3600 OAK MANOR LANE<br/>LARGO, FL 33774</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                        |
| A 082                                                | Continued From page 10<br><br>Findings included:<br><br>Personnel file review during the inspection found no documented evidence that either Staff C nor the administrator had obtained formal training covering _____ and _____.<br><br>Interview with the Director of Nursing at 1:25pm on _____ provided no clarification for this oversight.<br><br>Class III                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                | A 082                                                                                   |                                                                                                                          |                                                        |
| A 083<br>SS=D                                        | 59A-36.011(5) FAC Training - First Aid and _____<br><br>(5) FIRST AID AND _____. 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.<br>(a) Documentation that the staff member possess current _____ certification that requires the student to demonstrate, in person, that he or she is able to perform _____ and which is issued by an instructor or training provider that is approved to provide _____ training by the American Red Cross, the American _____ Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement.<br>(b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. |                                                                                | A 083                                                                                   |                                                                                                                          |                                                        |

Agency for Health Care Administration

|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                |                                                                                         |                                                                                                                          |                                                        |
|------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11910844</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                  |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/16/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAK MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3600 OAK MANOR LANE<br/>LARGO, FL 33774</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| A 083                                                | <p>Continued From page 11</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on record review and interview, the facility failed to ensure that two of three staff sampled (B; C) had received training in First Aid (FA) and ( ) in order to maintain staff in the facility at all times with said training.</p> <p>Findings included:</p> <p>Personnel file review during the survey revealed that neither Staff B (AM caregiver) nor Staff C (PM caregiver) had any official documentation verifying they had completed training in FA and .</p> <p>In an interview with the director of nursing at 1:40pm on , she indicated that they would be able to find other staff trained in FA/ who worked the same shifts as Staff B and C, but did not furnish necessary documentation.</p> <p>Class III</p> |                                                                                | A 083                                                                                   |                                                                                                                          |                                                        |
| A 091<br>SS=D                                        | <p>59A-36.011(12) FAC Training - Documentation &amp; Monitoring</p> <p>(12) TRAINING DOCUMENTATION AND MONITORING.</p> <p>(a) Except as otherwise noted, certificates, or copies of certificates, of any training required by this rule must be documented in the facility's personnel files. The documentation must include the following:</p> <ol style="list-style-type: none"> <li>1. The title of the training program,</li> <li>2. The subject matter of the training program,</li> <li>3. The training program agenda,</li> </ol>                                                                                                                                                                                                                                                                                  |                                                                                | A 091                                                                                   |                                                                                                                          |                                                        |

Agency for Health Care Administration

|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                |                                                                                                                          |                          |                                                        |
|------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11910844</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/16/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAK MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3600 OAK MANOR LANE<br/>LARGO, FL 33774</b>                                  |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 091                                                | <p>Continued From page 12</p> <p>4. The number of hours of the training program,<br/>5. The trainee's name, dates of participation, and<br/>location of the training program,<br/>6. The training provider's name, dated signature<br/>and credentials, and professional license number,<br/>if applicable.<br/>(b) Upon successful completion of training<br/>pursuant to this rule, the training provider must<br/>issue a certificate to the trainee as specified in<br/>this rule.<br/>(c) The facility must provide the Department of<br/>Elder Affairs and the Agency for Health Care<br/>Administration with training documentation and<br/>training certificates for review, as requested. The<br/>department and agency reserve the right to<br/>attend and monitor all facility in-service training,<br/>which is intended to meet regulatory<br/>requirements.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on record review and interview, the facility<br/>failed to ensure that all training certification<br/>included all required documented elements with<br/>respect to three of three staff sampled (B, C, D).</p> <p>Findings included:</p> <p>Personnel file review during the<br/>inspection revealed that Staff C received the 2 hr.<br/>preservice orientation, but this training was<br/>undated and unsigned by both the trainer and<br/>trainee. Further record review found that both<br/>Staff B and C had received the 1 hour elopement<br/>training, but again, this certificate was undated. In<br/>addition, Staff B and C had also received training<br/>in facility emergency procedures as well as<br/>control practices and safe food handling.<br/>Again, all three documents were undated. Finally,<br/>Staff C had an undated certificate regarding<br/>resident rights, while Staff B had one pertaining to</p> | A 091                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                      |                                                                                                                                                                                                          |                                                                                |                                                                                                                          |                          |                                                        |
|------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  |                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11910844</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/16/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAK MANOR</b> |                                                                                                                                                                                                          |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3600 OAK MANOR LANE<br/>LARGO, FL 33774</b>                                  |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                             | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 091                                                | Continued From page 13<br><br>..... Both training documents were not dated. Interview with the administrator and director of nursing provided no explanation regarding these omissions.<br><br>Class III | A 091                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                        |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11910844</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/16/2020</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**OAK MANOR**

**3600 OAK MANOR LANE  
LARGO, FL 33774**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| CZ816                    | <p>408.809(2a-c) 435.05(2) 59A-35.090(2d-3c)<br/>Background Screening-Compliance Attestation</p> <p>408.809 Background screening; prohibited offenses.-</p> <p>(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 _____. The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or</p> | CZ816               |                                                                                                                          |                          |

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                |                                                                                                                          |                          |                                                        |
|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11910844</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/16/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAK MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3600 OAK MANOR LANE<br/>LARGO, FL 33774</b>                                  |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| CZ816                                                | <p>Continued From page 1</p> <p>professional licensure requirements of 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:</p> <p>(a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section;</p> <p>(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</p> <p>(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.</p> <p>435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers:</p> <p>(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.</p> <p>59A-35.090 Background Screening.</p> <p>(2) Processing Screening Requests, Required Documents and Fees.</p> <p>(d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, _____, herein incorporated by reference, available at <a href="http://www.flrules.org/Gateway/reference.asp?No=Ref-09106">http://www.flrules.org/Gateway/reference.asp?No=Ref-09106</a>, and available from the Agency for Health Care Administration at: <a href="http://ahca.myflorida.com/MCHQ/Central_Service">http://ahca.myflorida.com/MCHQ/Central_Service</a></p> | CZ816                                                                          |                                                                                                                          |                          |                                                        |



Agency for Health Care Administration

|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                |                                                                                                                          |                          |                                                        |
|------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11910844</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/16/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OAK MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3600 OAK MANOR LANE<br/>LARGO, FL 33774</b>                                  |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| CZ816                                                | <p>Continued From page 2</p> <p>s/Background_Screening/Regulations_Forms.sht<br/>ml. This form must be completed by the individual<br/>and retained by the provider upon hire to attest<br/>that they meet the requirements for qualifying for<br/>employment, they have not been unemployed for<br/>more than 90 days from a position that requires<br/>Level 2 screening, and they agree to inform the<br/>employer immediately if _____ for any<br/>disqualifying offense.</p> <p>(e) An administrator or chief financial officer must<br/>be screened and qualified prior to _____ to<br/>the position.</p> <p>(3) Results of Screening and Notification.</p> <p>(a) Final results of background screening<br/>requests will be provided through the Agency's<br/>secure website that may be accessed by all<br/>health care providers applying for or actively<br/>licensed through the Agency that are registered<br/>with the Care Provider Background Screening<br/>Clearinghouse. The secure website is located at:<br/>apps.ahca.myflorida.com/SingleSignOnPortal.</p> <p>(b) If a Level 2 criminal history is incomplete, a<br/>certified letter will be sent to the individual being<br/>screened requesting the _____ report and court<br/>disposition information. If the letter is returned<br/>unclaimed, a copy of the letter will be sent by<br/>regular mail. Pursuant to section 435.05(1)(d),<br/>F.S., the missing information must be filed with<br/>the Agency within 30 days of the Agency's<br/>request or the individual is subject to<br/>disqualification in accordance with section<br/>435.06(3), F.S.</p> <p>(c) The eligibility results of employee screening<br/>and the signed Attestation referenced in<br/>subsection 59A-35.090(2), F.A.C., must be in the<br/>employee's personnel file, maintained by the<br/>provider.</p> <p>This Statute or Rule is not met as evidenced by:</p> | CZ816                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                        |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11910844</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/16/2020</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**OAK MANOR**

**3600 OAK MANOR LANE  
LARGO, FL 33774**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| CZ816                    | <p>Continued From page 3</p> <p>Based on record review and interview, the facility failed to ensure that one of four staff sampled (administrator) maintained an Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, . . . . . on the premises.</p> <p>Findings included:</p> <p>A review of the administrator's personnel file during the . . . . . inspection found no copy of the attestation of compliance with background screening requirements. Interview with the administrator at 12:45pm on . . . . . revealed that "his record was with the human resources office or else temporarily off the property."</p> | CZ816               |                                                                                                                          |                          |