

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11964082</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/11/2021</b> |
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**AUSTIN GROUP (THE)**

**1011 VAN DYKE ROAD  
LUTZ, FL 33548**

| (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 |
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| A 000                    | Initial Comments<br><br>A biennial re-licensure and complaint investigation (Complaint Number:2020006403 ) was conducted at The Austin group Assisted Living Facility on . Deficiencies were identified at the time of 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, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership.<br>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 . . . . .<br>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 . . . . . | A 078               |                                                                                                                          |                          |

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11964082</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/11/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>AUSTIN GROUP (THE)</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1011 VAN DYKE ROAD<br/>LUTZ, FL 33548</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 1</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 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 staff submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . . . . . for one (Administrator) of three staff sampled who had been employed at</p> | A 078                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>AUSTIN GROUP (THE)</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1011 VAN DYKE ROAD<br/>LUTZ, FL 33548</b>                                    |                          |                                                        |
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| A 078                                                         | Continued From page 2<br><br>least 30 days.<br><br>Findings include:<br><br>Personnel file review conducted on _____<br>revealed that the Administrator had no<br>documentation verifying that she had submitted a<br>written statement from a health care provider<br>documenting that she does not have any signs or<br>symptoms of communicable _____<br><br>Interview with the Assistant Administrator on<br>_____ at 10:32am, she stated she made a list<br>of missing documentation and stated she would<br>look for them. Follow-up interview conducted on<br>_____ at 12:30pm, the Assistant Administrator<br>assistant acknowledged she did not have the<br>required documentation.<br><br>Class III                                        | A 078                                                                          |                                                                                                                          |                          |                                                        |
| A 081<br>SS=D                                                 | 429.52(1 & 7) FS; 59A-36.011( ) FAC Training<br>- Staff In-Service<br><br>429.52(1)<br>(1)Each new assisted living facility employee who<br>has not previously completed core training must<br>attend a preservice orientation provided by the<br>facility before interacting with residents. The<br>preservice orientation must be at least 2 hours in<br>duration and cover topics that help the employee<br>provide responsible care and respond to the<br>needs of facility residents. Upon completion, the<br>employee and the administrator of the facility<br>must sign a statement that the employee<br>completed the required preservice orientation.<br>The facility must keep the signed statement in the<br>employee's personnel record. | A 081                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

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| A 081                                                         | <p>Continued From page 3</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 employee completed the preservice orientation which must be kept in the employee's personnel record.<br/>(d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover:<br/>1. Resident's rights; and,<br/>2. The facility's license type and services offered by the facility.<br/>(3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff:<br/>(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,</p> | A 081                                                                          |                                                                                                                          |                          |                                                        |

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| A 081                                                         | Continued From page 4<br><br>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 _____ borne _____, may be used to meet this requirement.<br><br>(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:<br>1. Reporting adverse incidents.<br>2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation.<br><br>(c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects:<br>1. Resident rights in an assisted living facility.<br>2. Recognizing and reporting resident _____, neglect, and _____. The facility must use its _____ prevention policies and procedures when offering this training.<br><br>(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:<br>1. Resident behavior and needs.<br>2. Providing assistance with the activities of daily living.<br><br>(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 | A 081                                                                          |                                                                                                                          |                          |                                                        |

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**AUSTIN GROUP (THE)**

**1011 VAN DYKE ROAD  
LUTZ, FL 33548**

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| A 081                    | <p>Continued From page 5</p> <p>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> <p>1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures.</p> <p>2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures.</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 (Staff B) of three staff sampled who had been employed at least 30 days had not taken 2-Hour pre service orientation, 1 hour Assistance in activities of daily living (ADL), incident report and elopement training.</p> <p>Findings include:</p> <p>Personnel file review conducted on _____ revealed that Staff B, hired _____, had no documentation verifying that staff had received 2-hour Pre-Service orientation and a minimum of 1 hour in service training in assistance in activities of daily living, incident report and elopement.</p> <p>Interview with the Assistant Administrator on _____ at 10:32am, she stated she made a list of missing documentation and stated she would look for them. Follow-up interview conducted on _____</p> | A 081               |                                                                                                                          |                          |

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| A 081                                                         | Continued From page 6<br><br>..... at 12:30pm, the Assistant Administrator<br>assistant acknowledged she did not have the<br>required documentation.<br><br>Class III                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | A 081                                                                                 |                                                                                                                          |                                                        |
| A 090<br>SS=D                                                 | 59A-36.011(11) FAC Training - .....<br><br>(11)<br>TRAINING.<br>(a) Currently employed facility administrators,<br>managers, direct care staff and staff involved in<br>resident admissions must receive at least one<br>hour of training in the facility's policies and<br>procedures regarding<br>(b) Newly hired facility administrators, managers,<br>direct care staff and staff involved in resident<br>admissions must receive at least one hour of<br>training in the facility's policy and procedures<br>regarding ..... within 30 days after<br>employment.<br>(c) Training shall consist of the information<br>included in rule 59A-36.009, F.A.C.<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 one (Staff B) of three staff<br>sampled who had been employed at least 30<br>days had not taken 1 hour in the facility's policies<br>and procedures regarding .....<br>( ..... ).<br><br>Findings include:<br><br>Personnel file review conducted on<br>revealed that Staff B, hired ..... had no<br>documentation verifying that staff had received<br>1-hour training in the facility's policies and | A 090                                                                                 |                                                                                                                          |                                                        |

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| A 090                                                         | Continued From page 7<br><br>procedures regarding . . . . .<br><br>Interview with the Assistant Administrator on<br>at 10:32am, she stated she made a list<br>of missing documentation and stated she would<br>look for them. Follow-up interview conducted on<br>at 12:30pm, the Assistant Administrator<br>assistant acknowledged she did not have the<br>required documentation.<br><br>Class III                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | A 090                                                                          |                                                                                                                          |                          |                                                        |
| A 162<br>SS=D                                                 | 59A-36.015(3) FAC Records - Resident<br><br>(3) RESIDENT RECORDS. Resident records<br>must be maintained on the premises and include:<br>(a) Resident demographic data as follows:<br>1. Name,<br>2. . . . .<br>3. Race,<br>4. Date of birth,<br>5. Place of birth, if known,<br>6. Social security number,<br>7. Medicaid and/or Medicare number, or name of<br>other health insurance . . . . .<br>8. Name, address, and telephone number of next<br>of kin, legal representative, or individual<br>designated by the resident for notification in case<br>of an emergency; and,<br>9. Name, address, and telephone number of the<br>health care provider and case manager, if<br>applicable.<br>(b) A copy of the Resident Health Assessment<br>form, AHCA Form 1823 described in rule<br>59A-36.006, F.A.C.<br>(c) Any orders for medications, nursing services,<br>therapeutic diets, . . . . . or<br>other services to be provided, supervised, or<br>implemented by the facility that require a health | A 162                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11964082</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/11/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>AUSTIN GROUP (THE)</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1011 VAN DYKE ROAD<br/>LUTZ, FL 33548</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 162                                                         | Continued From page 8<br><br>care provider's order.<br>(d) Documentation of a resident's refusal of a<br>therapeutic diet pursuant to rule 59A-36.012,<br>F.A.C., if applicable.<br>(e) The resident care record described in<br>paragraph 59A-36.007(1)(e), F.A.C.<br>(f) A _____ record that is initiated on admission.<br>Information may be taken from AHCA Form 1823<br>or the resident's health assessment. Residents<br>receiving assistance with the activities of daily<br>living must have their _____ recorded<br>semi-annually.<br>(g) For facilities that will have unlicensed staff<br>assisting the resident with the self-administration<br>of medication, a copy of the written informed<br>consent described in rule 59A-36.006, F.A.C., if<br>such consent is not included in the resident's<br>contract.<br>(h) For facilities that manage a pill organizer,<br>assist with self-administration of medications or<br>administer medications for a resident, copies of<br>the required medication records maintained<br>pursuant to rule 59A-36.008, F.A.C.<br>(i) A copy of the resident's contract with the<br>facility, including any addendums to the contract<br>as described in rule 59A-36.018, F.A.C.<br>(j) For a facility whose owner, administrator, staff,<br>or representative thereof, serves as an attorney in<br>fact for a resident, a copy of the monthly written<br>statement of any transaction made on behalf of<br>the resident as required in section 429.27, F.S.<br>(k) For any facility that maintains a separate trust<br>fund to receive funds or other property belonging<br>to or due a resident, a copy of the quarterly<br>written statement of funds or other property<br>disbursed as required in section 429.27, F.S.<br>(l) If the resident is an _____ recipient, a copy of<br>the Department of Children and Families form<br>Alternate Care Certification for Optional State | A 162                                                                          |                                                                                                                          |  |                                                        |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>AUSTIN GROUP (THE)</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1011 VAN DYKE ROAD<br/>LUTZ, FL 33548</b> |                                                                                                                          |                                                        |
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| A 162                                                         | Continued From page 9<br><br>Supplementation ( . . . ), CF-ES 1006, . . . . .<br>which is hereby incorporated by reference<br>and available for review at:<br><a href="http://www.flrules.org/Gateway/reference.asp?No=Ref-04004">http://www.flrules.org/Gateway/reference.asp?No=Ref-04004</a> . The absence of this form will not be<br>the basis for administrative action against a<br>facility if the facility can demonstrate that it has<br>made a good faith effort to obtain the required<br>documentation from the Department of Children<br>and Families.<br>(m) Documentation of the . . . . . of a<br>health care surrogate, health care proxy,<br>guardian, or the existence of a power of attorney,<br>where applicable.<br>(n) For hospice patients, the interdisciplinary care<br>plan and other documentation that the resident is<br>a hospice patient as required in rule 59A-36.006,<br>F.A.C.<br>(o) The resident's . . . . . , DH<br>Form 1896, if applicable.<br>(p) For independent living residents who receive<br>meals and occupy beds included within the<br>licensed capacity of an assisted living facility, but<br>who are not receiving any personal, limited<br>nursing, or extended congregate care services,<br>record keeping may be limited to the following at<br>the discretion of the facility:<br>1. A log listing the names of residents<br>participating in this arrangement,<br>2. The resident demographic data required in this<br>paragraph,<br>3. The health assessment described in rule<br>59A-36.006, F.A.C.,<br>4. The resident's contract described in rule<br>59A-36.018, F.A.C.; and,<br>5. A health care provider's order for a therapeutic<br>diet if such diet is prescribed and the resident<br>participates in the meal plan offered by the<br>facility. | A 162                                                                                 |                                                                                                                          |                                                        |

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11964082</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/11/2021</b> |
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**AUSTIN GROUP (THE)**

**1011 VAN DYKE ROAD  
LUTZ, FL 33548**

| (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 |
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| A 162                    | <p>Continued From page 10</p> <p>(q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility.</p> <p>(r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on record review and interview, the facility failed to maintain and updated Health Assessment 1823 and Hospice interdisciplinary care plan documentation for one (Resident #1) of one resident sampled.</p> <p>Finding include:</p> <p>A record review was conducted on _____ for Resident # 1 revealed she was admitted to hospice _____, Resident # 1 did not have an updated health assessment 1823 to reflect Hospice (significant change) and a Hospice interdisciplinary care plan.</p> <p>Interview conducted on _____ at 12:30pm, the Assistant Administrator assistant acknowledged she did not have the required documentation.</p> <p>Class III</p> | A 162               |                                                                                                                          |                          |

Agency for Health Care Administration

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| CZ816                    | Continued From page 11                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | CZ816               |                                                                                                                          |                          |
| 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.-<br/>(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</p> | CZ816               |                                                                                                                          |                          |

Agency for Health Care Administration

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| CZ816                                                         | <p>Continued From page 12</p> <p>with level 2 screening standards submitted within the previous 5 years to meet any provider or 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</p> | CZ816                                                                          |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11964082</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/11/2021</b> |
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NAME OF PROVIDER OR SUPPLIER

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| CZ816                    | <p>Continued From page 13</p> <p>Health Care Administration at:<br/><a href="http://ahca.myflorida.com/MCHQ/Central_Service/Background_Screening/Regulations_Forms.shtml">http://ahca.myflorida.com/MCHQ/Central_Service/Background_Screening/Regulations_Forms.shtml</a>. This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if _____ for any disqualifying offense.</p> <p>(e) An administrator or chief financial officer must be screened and qualified prior to _____ to the position.</p> <p>(3) Results of Screening and Notification.</p> <p>(a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: <a href="http://apps.ahca.myflorida.com/SingleSignOnPortal">apps.ahca.myflorida.com/SingleSignOnPortal</a>.</p> <p>(b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the _____ report and court disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with section 435.06(3), F.S.</p> <p>(c) The eligibility results of employee screening and the signed Attestation referenced in subsection 59A-35.090(2), F.A.C., must be in the employee's personnel file, maintained by the provider.</p> | CZ816               |                                                                                                                          |                          |

Agency for Health Care Administration

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| CZ816                                                         | <p>Continued From page 14</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on interview and record review, the facility failed to maintain record of an Attestation of Compliance with Background Screening Requirements, AHCA Form3100-008, _____, for three staff (Administrator, Asssitant Administrator and Staff B) of three staff sampled.</p> <p>Findings include:</p> <p>Personnel file review conducted on _____ revealed that the Administrator, Asssitant Administrator and Staff B did not have a signed Attestation of Compliance with Background Screening Requirements in there file.</p> <p>Interview with the Assistant Administrator on _____ at 10:32am, she stated she made a list of missing documentation and stated she would look for them. Follow-up interview conducted on _____ at 12:30pm, the Assistant Administrator assistant acknowledged she did not have the required documentation.<br/>Unclassified</p> | CZ816                                                                          |                                                                                                                          |  |                                                        |