Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968763	A. BUILDING: _____ B. WING _____	05/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAYMAN CIRCLE ADULT FAMILY CARE	5843 CAYMAN CR WEST WEST PALM BEACH, FL 33407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Unannounced Abbreviated Relicensure, Generator Assessment Monitoring and Focused Control surveys were conducted on [redacted] at Cayman Circle Adult Family Care. The facility had deficiencies identified related to the Abbreviated Relicensure survey at the time of the visit.	A 000		
A 010	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is	A 010		

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A 010	Continued From page 1	A 010		

agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care.
(d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to:
a. Move, turn, or reposition without total physical assistance;
b. Transfer to a chair or wheelchair without total physical assistance; or
c. Sit safely in a chair or wheelchair without personal assistance or a physical . . . . .
2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days.
3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days.
(2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident ' s representative or designee or the resident ' s family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact

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A 010	Continued From page 2	A 010		

person in the applicable department.
(3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility.

59A-36.006
(4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 59A-36.002, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are:
(a) The resident may be bedridden for no more than 7 consecutive days.
(b) A resident requiring care of a , may be retained provided that:
1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider,
2. The condition is documented in the resident's record; and,
3. If the resident's condition fails to improve within 30 days, as documented by a health care provider, the resident must be discharged from

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A 010	Continued From page 3 the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by:	A 010		

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A 010	Continued From page 4 Based on observation, record review and interviews, it was determined that the facility Administrator failed to assess the continued appropriateness of placement of a resident in the Assisted Living Facility for 1 of 2 sampled residents (Resident #2). The findings included: On , Resident #2's most recent health assessment (AHCA Form 1823) dated was reviewed. The assessment documented that the resident was "assisted" with ambulation and transfers, requiring "moderate to with transfers". It was also documented that the resident had a " , 3 or 4 , " with no noted explanation in the comments section. The assessment also has "No" marked as an answer to the inquiry as to whether the resident is bedridden, and explains that the resident is "OOB (out of bed) with assistance to w/c (wheelchair)". Resident #2 was observed lying flat on his in bed at 9:45 AM, again at 10:05 AM and 11:30 AM. The resident was unable to answer questions appropriately when asked if he was getting out of the bed at any time. The Administrator stated during an interview conducted on at 10:00 AM, she did not know when the last time the resident was out of bed, and stated "it takes two people". Only one staff member (Staff B) was observed at the facility on this date at 9:15 AM. When asked for the written work schedule, the Administrator stated she did not have one at this time. She also stated that the one staff member on duty worked days, from approximately 7:00 AM to 7:00 PM, and that she (Administrator) was the staff	A 010		

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A 010	Continued From page 5 member present at night from 7:00 PM to 7:00 AM. During an interview conducted with the Resident #2's representative on at 10:32 AM, the representative stated that the resident 'stays in bed now and does not get up in his wheelchair or get out of his room anymore'. The representative further stated the resident 'cannot move the left side of his body as he had a and it is very difficult to get him out of bed'. Review of the resident's record revealed a Communication Note by a Home Health Agency representative documenting that the resident had a "L (left) heel " on . Additional documentation notes " care done" on various dates through . There was no documentation at the facility available for review of the type of , stage of the , date of onset or current status. At 10:17 AM, the Registered Nurse (RN) with the Home Health Agency that was caring for the was interviewed by phone. When asked what stage the pressure injury was at this time, he stated "a , but now it's a " and directed this writer to request records from the Home Health Agency for additional information. Subsequently, a request was made for Resident #2's records for care from the Home Health Agency and were received on . Review of the Home Health Agency documentation of the resident's that was identified as being on the resident's left outer ankle/heel revealed the following: : Referred for home health services, pressure injury; care "cleanse with normal , , dry, apply	A 010		

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A 010	Continued From page 6 [redacted], dry gauze" Monday, Wednesday, Friday for 4 weeks; "complete bed rest"/"bedbound"; "left sided [redacted]"; no effort from resident for him to roll left to right, caregiver must make all the effort. Further review of the Skilled Nursing Home Health Progress Notes completed by the RN revealed for the following dates: [redacted] - [redacted] pressure injury with [redacted] care; "caregiver with good return demo of [redacted] care and [redacted] change...to assist with Friday [redacted] changes"; resident is "bedbound"; caregiver to "turn and reposition q (every) 2 hours"; date of onset [redacted]. Additionally, the RN documents Resident #2 requires [redacted] with activities of daily living, meals, medications, skin care and is [redacted] of [redacted] and [redacted]. Further, the resident's [redacted] status is disoriented to time and place. On [redacted], after a request was made to the Administrator for information about the resident's pressure injury, a faxed document from the resident's health care provider was received at the facility. Review of the health care provider's [redacted] Assessment Details dated [redacted] revealed the resident's "left heel medial pressure injury" was a [redacted]. The note also documented another [redacted] pressure injury on the resident's left [redacted], date of onset [redacted]. During a subsequent interview conducted with the Administrator at 11:45 AM, she stated she did not have any documentation of the [redacted] pressure injury on the resident's left [redacted] because she "didn't know it was a [redacted] since they told me to put (diaper cream) on it, and I call the doctor right away". She stated she had not identified this	A 010		

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A 010	Continued From page 7 resident as inappropriate for continued residency. The resident's previous [illegible] pressure injury to the left heel which was now identified as a [illegible] pressure injury, failure to document the condition of a second [illegible] pressure injury to the left [illegible] in the resident's record, the bedridden status of the resident for more than seven (7) consecutive days, the resident requiring [illegible] with all activities of daily living due to left sided [illegible] of [illegible] and [illegible] and the inability of the facility to assist the resident with transferring out of bed due to his need for two staff to assist, deemed this resident inappropriate for continued residency at this Assisted Living Facility. The facility provided no additional information for review at the time of the survey. Class III	A 010		
A 026	59A-36.007(2) FAC Resident Care - Social & Leisure Activities (2) SOCIAL AND LEISURE ACTIVITIES. Residents shall be encouraged to participate in social, recreational, educational and other activities within the facility and the community. (a) The facility must provide an ongoing activities program. The program must provide diversified individual and group activities in keeping with each resident's needs, abilities, and interests. (b) The facility must consult with the residents in selecting, planning, and scheduling activities. The facility must demonstrate residents' participation through one or more of the following methods: resident meetings, committees, a resident council, a monitored suggestion box, group discussions, questionnaires, or any other form of	A 026		

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A 026	Continued From page 8 communication appropriate to the size of the facility. (c) Scheduled activities must be available at least 6 days a week for a total of not less than 12 hours per week. Watching television is not an activity for the purpose of meeting the 12 hours per week of scheduled activities unless the television program is a special one-time event of special interest to residents of the facility. A facility whose residents choose to attend day programs conducted at adult day care centers, senior centers, mental health centers, or other day programs may count those attendance hours towards the required 12 hours per week of scheduled activities. An activities calendar must be posted in common areas where residents normally congregate. (d) If residents assist in planning a special activity such as an outing, seasonal festivity, or an excursion, up to 3 hours may be counted toward the required activity time. This Statute or Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to schedule resident activities that addressed the resident's needs, abilities and interests for a minimum of 12 hours per week. The findings included: During review of the activities calendar observed posted on a wall in the dining room area of the facility on , it was noted there was one activity scheduled per day, including church/religious preference, walk/chair exercises, movie, coffee talk, board game and bingo. Each of these activities did not document a time that they ended, and totaled approximately seven (7) hours for the week's total time of activities	A 026		

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A 026	Continued From page 9 scheduled. During an interview conducted with Resident #1 at 9: 20 AM on , he stated that there were no activities at the facility, and that he would like to find a way to go out to run errands but he had no way to find transportation. He was admitted on . During an interview conducted with Resident #3 on at 10:10 AM, she stated they used to have board games but they have not had them since COVID, and stated she did not like to play bingo. The Administrator stated during an interview conducted at 10:30 AM, that the current schedule was from before COVID, and they were not able to do group activities because of COVID. She acknowledged that the residents did not do the current activities listed on the calendar and alternate activities had not been arranged. When asked what activities the facility did provide, she stated Resident #3 did crossword puzzles for an activity. The facility provided no additional documentation for review at the time of the survey. Class III	A 026		
A 078	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have	A 078		

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A 078	Continued From page 10 been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative . . . . . examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual . . . . . examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . . . . . . 2. If any staff member has, or is suspected of having, a communicable . . . . . , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . . . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility . . . . . to	A 078		

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A 078	Continued From page 11 provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff . . . . . by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure 1 out of 2 sampled employees (Staff B) had submitted a written statement from a health care provider documenting that the employee does not have any signs or symptoms of communicable , ( ). The findings included: Staff B was observed in sole charge of residents at the facility on . . . . at 9:15 AM. During an interview conducted with Resident #1 at 9:20 AM on . . . . , he stated Staff B had been working at the facility since he was admitted on . During review of the personnel file for Staff B on . . . . . , a signed statement by a health care provider verifying this employee was free from all communicable . . . . . , including . , could not be found.	A 078		

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A 078	Continued From page 12 During an interview conducted with the Administrator at 11:15 AM on [redacted], she stated Staff B had worked at the facility "since [redacted]," 2021, and she had not completed the employee's personnel file yet. The facility provided no additional documentation for review at this time. Class III	A 078		
A 079	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents — Staff Hours/Week 0-5 — 168 6-15 — 212 16-25 — 253 26-35 — 294 36-45 — 335 46-55 — 375 56-65 — 416 66-75 — 457 76-85 — 498 86-95 — 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care	A 079		

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services, are not counted as residents for purposes of computing minimum staff hours.
3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility.
4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night.
5. A staff member who has completed courses in First Aid and [illegible] ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times.
a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement.
b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and .
6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least [illegible] must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager.
7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food

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A 079	Continued From page 14	A 079		

preparation do not count towards meeting the minimum staffing hours requirement.
8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule.
9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted.
(b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C.
(c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives.
(d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents'

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A 079	Continued From page 15 contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by:	A 079		

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A 079	Continued From page 16 Based on record review and interview, the facility failed to maintain a written work schedule which reflects the facility's 24 hour staffing pattern for a given time period; and, failed to ensure at least one staff member with documentation of training in First Aid and was in the facility at all times. The findings included: a. On at 10:00 AM, the written work schedule was requested from the Administrator. She stated that she did not have a written work schedule at this time. The facility provided no additional documentation for review at the time of the survey. b. On at 9:15 AM, Staff B was observed in sole charge of three residents at the facility. During review of Staff B's personnel file on , there was no documentation of training in First Aid and found. The Administrator stated during an interview conducted at 11:15 AM on that Staff B had completed the training but was unable to present the documentation to show completion. The facility provided no additional documentation for review at the time of the survey. Class III	A 079		
A 081	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52(1) (1)Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the	A 081		

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A 081	Continued From page 17 facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in 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. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and,	A 081		

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A 081	Continued From page 18 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in [illegible] control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its [illegible] control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to [illegible] borne [illegible], may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident [illegible], neglect, and [illegible]. The facility must use its [illegible] prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents,	A 081		

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A 081	Continued From page 19 other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 2 out of 2 sampled staff (Staff A and Staff B) had completed 2 hours of Preservice Orientation signed by the Administrator and staff member prior to interacting with residents; and, failed to ensure that 1 out of 2 sampled staff (Staff B) who provide direct care to residents had received the required in-service training within 30 days of employment. The findings included:	A 081		

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A 081	Continued From page 20 Staff B was observed in sole charge of residents at the facility on . . . . . at 9:15 AM. During an interview conducted with Resident #1 at 9:20 AM on . . . . . , he stated Staff B had been working at the facility since he was admitted on . During an interview conducted with the Administrator at 11:15 AM on , she stated Staff B had worked at the facility "since , ". The Administrator stated that Staff A was the other staff member who worked during the day shift with residents, from approximately 7:00 AM to 7:00 PM. Staff A's date of hire was . a. Review of the personnel files for Staff A and Staff B who work as caregivers for residents revealed no certificates of a 2 hour Pre-Service orientation on file, including training in Residents' Rights and ALF (Assisted Living Facility) services, signed by both the Administrator and the employee. b. Review of the personnel file also revealed there was no documentation of the following required in-service training dated within 30 days of employment for Staff B who was hired in , : 1. Facility's Emergency Procedures and Incident Reporting (1 hour required) 2. Residents' Rights and , Neglect and , ... (1 hour required) 3. Facility's / 's (1 hour required) 4. Control (1 hour required) 5. Activities of Daily Living (3 hours required) 6. Safe Food Handling (1 hour required) 7. Facility's Elopement Policy and Procedure (no time required)	A 081		

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A 081	Continued From page 21 The Administrator stated during an interview conducted at 11:15 AM on , that the aforementioned training documentation was not present and available for review. The facility provided no additional documentation of the required training for this staff member at this time. Class III	A 081		
A 082	59A-36.011(4) FAC Training - / (4) / (/). Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on and , including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that 1 out of 2 sampled staff (Staff B) had completed training on / within 30 days of employment. The findings included: The personnel file for Staff B was reviewed on for documentation of training in / dated within 30 days of employment. There was no documentation of this training available for review. The Administrator stated	A 082		

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A 082	Continued From page 22 during an interview conducted at 11:15 AM on that the documentation was not present and available for review, and Staff B had worked at the facility "since ,". The facility presented no additional documentation for review at the time of the survey. Class III	A 082		
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain	CZ814		

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CZ814	Continued From page 23 a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on observation, review of the Agency's Criminal Background Screening Clearinghouse website and interview, the facility failed to maintain a current employee roster for all employees of the facility. 1 out of 2 sampled staff, Staff B, was not listed on the roster. The findings included: Staff B was observed in sole charge of residents at the facility on at 9:15 AM. During an interview conducted with Resident #1 at 9:20 AM on , he stated Staff B had been working at the facility since he was admitted on . During an interview conducted with the Administrator at 11:15 AM on , she stated Staff B had worked at the facility "since ," 2021, but that she had not completed the personnel file since she was "opening another facility". On , a review was conducted of the facility's employee roster located on the Agency's Background Screening Clearinghouse website. At this time, Staff B was still not listed on the roster. Unclassified	CZ814		
CZ815	408.809(1)( ); 435.02(2); 435.06 FS Background Screening; Prohibited Offenses 408.809 Background screening; prohibited offenses.- (1) Level 2 background screening pursuant to	CZ815		

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CZ815	Continued From page 24 chapter 435 must be conducted through the agency on each of the following persons, who are considered employees for the purposes of conducting screening under chapter 435: (a) The licensee, if an individual. (b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider. (c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider. (d) Any person who is a controlling interest. (e) Any person, as required by authorizing statutes, seeking employment with a licensee or provider who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, ␣ with a licensee or provider whose responsibilities require him or her to provide personal care or personal services directly to clients, or ␣ with a licensee or provider to work 20 hours a week or more who will have access to client funds, personal property, or living areas. Evidence of contractor screening may be retained by the contractor's employer or the licensee. (3) All ␣ , must be provided in electronic format. Screening results shall be reviewed by the agency with respect to the offenses specified in s. 435.04 and this section, and the qualifying or disqualifying status of the person named in the request shall be maintained in a database. The qualifying or disqualifying status of the person named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee's behalf.	CZ815		

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CZ815	Continued From page 25 (4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an . . . . awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction: (a) Any authorizing statutes, if the offense was a felony. (b) This chapter, if the offense was a felony. (c) Section 409.920, relating to Medicaid provider fraud. (d) Section 409.9201, relating to Medicaid fraud. (e) Section 741.28, relating to domestic violence. (f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection. (g) Section 784.03, relating to battery, if the victim is a adult as defined in s. 415.102 or a patient or resident of a facility licensed under chapter 395, chapter 400, or chapter 429. (h) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems. (i) Section 817.234, relating to false and fraudulent insurance claims. (j) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony. (k) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider. (l) Section 817.505, relating to patient brokering. (m) Section 817.568, relating to criminal use of	CZ815		

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CZ815	Continued From page 26 personal identification information. (n) Section 817.60, relating to obtaining a credit card through fraudulent means. (o) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony. (p) Section 831.01, relating to forgery. (q) Section 831.02, relating to uttering forged instruments. (r) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes. (s) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes. (t) Section 831.30, relating to fraud in obtaining medicinal drugs. (u) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony. (v) Section 895.03, relating to racketeering and collection of unlawful debts. (w) Section 896.101, relating to the Florida Money Laundering Act. If, upon rescreening, a person who is currently employed or . . . . . with a licensee and was screened and qualified under s. 435.04 has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency no later than 30 days after receipt of the rescreening results by the person.	CZ815		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ815	Continued From page 27 (5) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening. (6)(a) As provided in chapter 435, the agency may grant an exemption from disqualification to a person who is subject to this section and who: 1. Does not have an active professional license or certification from the Department of Health; or 2. Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification. (b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may grant an exemption from disqualification to a person who is subject to this section and who has received a professional license or certification from the Department of Health or a regulatory board within that department and that person is providing a service within the scope of his or her licensed or certified practice. (7) The agency and the Department of Health may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, chapter 435, and authorizing statutes requiring background screening and to implement and adopt criteria relating to retaining , pursuant to s. 943.05(2). (8) There is no reemployment assistance or other	CZ815		

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	AL11968763	A. BUILDING: _____ B. WING _____	05/10/2021

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monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this section, terminates the person against whom the report was issued, whether or not that person has filed for an exemption with the Department of Health or the agency.

435.06 Exclusion from employment.-
(1) If an employer or agency has reasonable cause to believe that grounds exist for the denial or termination of employment of any employee as a result of background screening, it shall notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity.
(2)(a) An employer may not hire, select, or otherwise allow an employee to have contact with any person that would place the employee in a role that requires background screening until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of employment. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select, or otherwise allow the employee to have contact with any person that would place the employee in a role that requires background screening unless the employee is granted an exemption for the disqualification by the agency as provided under s. 435.07.
(b) If an employer becomes aware that an employee has been for a disqualifying

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offense, the employer must remove the employee from contact with any person that places the employee in a role that requires background screening until the is resolved in a way that the employer determines that the employee is still eligible for employment under this chapter.
(c) The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of this chapter or place the employee in a position for which background screening is not required unless the employee is granted an exemption from disqualification pursuant to s. 435.07.
(d) An employer may hire an employee to a position that requires background screening before the employee completes the screening process for training and orientation purposes. However, the employee may not have direct contact with persons until the screening process is completed and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment.
(3) Any employee who refuses to cooperate in such screening or refuses to timely submit the information necessary to complete the screening, including , if required, must be disqualified for employment in such position or, if employed, must be dismissed.
(4) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages against, an employer that, upon notice of a conviction or for a disqualifying offense listed under this chapter, terminates the person against whom the report was issued or who was , regardless of whether or not that person has filed for an exemption pursuant to this chapter.

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CZ815	Continued From page 30 435.02 Definitions.-For the purposes of this chapter, the term: (2) "Employee" means any person required by law to be screened pursuant to this chapter, including, but not limited to, persons who are contractors, licensees, or volunteers. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that 1 out of 2 sampled staff (Staff B) who provided personal care services for residents was in compliance with the Level II criminal background screening requirement. The findings included: Staff B was observed in sole charge of residents at the facility on at 9:15 AM. During an interview conducted with Resident #1 at 9:20 AM on , he stated Staff B had been working at the facility since he was admitted on . During an interview conducted with the Administrator at 11:15 AM on , she stated Staff B had worked at the facility "since ," 2021, but that she had not completed the personnel file since she was "opening another facility". She stated Staff B had a background screening completed, but she did not have a copy to show completion. The personnel file for Staff B was reviewed for documentation of compliance with the Level II criminal background screening requirement. There was no documentation of this screening on file. On , a review was conducted of the Agency's Background Screening Clearinghouse website. Under the Determination of Eligibility column, there was documentation that "A New	CZ815		

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CZ815	Continued From page 31 Screening Is Required". There was no record of a completed screening with an eligibility to work status with no disqualifying offenses on the Agency's background screening website. Unclassified	CZ815		
CZ830	408.821( ) FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for	CZ830		

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CZ830	Continued From page 32 up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be	CZ830		

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CZ830	Continued From page 33 current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to submit their Comprehensive Emergency Management Plan (CEMP) revisions within 30 days after notification of the need for revisions by the County Emergency Management planning department for approval. The findings included: On . . . . . at 10:50 AM, the Administrator stated during an interview, she did not have a current approved CEMP and did not know when the last plan was submitted to the County. The plan is approved by the County for one (1) year, with the requirement that the facility resubmit the plan at least annually. A representative from the County Emergency Management planning department documented in an email response on at 3:51 PM, that the facility's last approved plan was . . . . . The facility had submitted their annual plan last on , and was notified of their unapproved plan and need for revisions in a letter sent by the County Emergency Management planning department dated . There had been no submission of revisions received by the county as of . The facility provided no additional documentation for review at the time of the survey.	CZ830		

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CZ830	Continued From page 34 Unclassified	CZ830		