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
	AL11911328	A. BUILDING: _____ B. WING _____	06/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER TOWERS	70 WEST LUCERNE CIRCLE ORLANDO, FL 32801

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A 000	Initial Comments A re-licensure survey, control assessment and generator monitoring were conducted at Westminster Towers Assisted Living Facility with Extended Congregate Care (ECC) on . The provider had deficiencies at the time of the visit.	A 000		
A 004 SS=D	59A-36.004 FAC Licensure - Requirements (1) SERVICE PROHIBITION. An assisted living facility may not represent that it provides any service other than a service for which it is licensed to provide. (2) CHANGE IN USE OF SPACE REQUIRING AGENCY CENTRAL OFFICE APPROVAL. A change in the use of space that increases or decreases a facility's capacity must not be made without prior approval from the Agency Central Office. Approval must be based on the compliance with the physical plant standards provided in rule 59A-36.014, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation inspection requirements referenced in rule 59A-36.005, F.A.C. (3) CHANGE IN USE OF SPACE REQUIRING AGENCY FIELD OFFICE APPROVAL. A change in the use of space that involves converting an area to resident use, which has not previously been inspected for such use, must not be made without prior approval from the Agency Field Office. Approval must be based on compliance with the physical plant standards provided in rule 59A-36.014, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation inspection standards referenced in rule 59A-36.005, F.A.C. (4) CONTIGUOUS PROPERTY. If a facility consists of more than one building, all buildings included under a single license must be on	A 004		

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A 004	Continued From page 1 contiguous property. "Contiguous property" means property under the same ownership separated by no more than a two-lane street that traverses the property. A licensed location may be expanded to include additional contiguous property with the approval of the agency to ensure continued compliance with the requirements and standards of chapters 408, Part II, 429, Part I, F.S. and rule chapter 59A-35, F.A.C., and this rule chapter. (5) PROOF OF INSPECTIONS. A copy of the annual fire safety and sanitation inspections described in rule 59A-36.005, F.A.C., must be submitted annually to the Agency Central Office. The annual inspections must be submitted no later than 30 calendar days after the inspections. Failure to comply with this requirement may result in administrative action pursuant to chapter 408, part II, and section 429.14, F.S., and rule chapter 59A-35, F.A.C. (6) RESIDENTS RECEIVING STATE-FUNDED SERVICES. Upon request, the facility administrator or designee must identify residents receiving state-funded services to the agency and the department for monitoring purposes authorized by state and federal laws. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to notify the Agency regarding a change in use of space on the fourth floor, not licensed as an Assisted Living Facility that requires the Field Office approval and the Central Office approval from the Agency for Health Care Administration (AHCA) to ensure compliance with the Fire Safety department and sanitation department of Health as required. Findings:	A 004		

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A 004	Continued From page 2 On . . . . . at 9:30 AM, an interview with the Administrator confirmed that some Assisted Living Facility (ALF) residents were located on the 4th floor of the facility. It was asked if he contacted the Agency regarding to change of use of space approval. The Administrator answered no because he did not exceed his facility capacity of 60. The current census for ALF residents was 41. It was explained that prior approval must be made first before changing space location. It was explained that in the past surveys conducted only the 2nd and 3rd floors were licensed for ALF residents. The 4th floor was designated for independent living. Observation on at 10 AM, # -404, #405-407, #406-408, #409, #410, #412, #416-418 were bigger rooms and occupied ALF residents. . . . # . , # , . # . were confirmed as independent living residents. For # -404; #405-407; #406-408; and #416-418 are all occupied with ALF resident couples. The space was measured and adequate size to meet criteria of changing space. (Photographic Evidence Obtained) On . . . . . at 4:30 PM, an exit interview with the Administrator, Executive Director, and Director of Nursing (DON) confirmed the findings. In addition, the Administrator stated he would follow up with the Field Office for guidance moving forward. Class III	A 004		
A 032 SS=D	59A-36.007(8) FAC Resident Care - Elopement Standards	A 032		

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A 032	Continued From page 3 59A-36.007 (8) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response	A 032		

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A 032	Continued From page 4 Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to sections 429.41(1)(a)3. and 429.41(1)(l), F.S. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 2 direct care staff participated in a minimum of two resident elopement drills each year (A & C). Findings: At 1:10 p.m. on . . . . . caregiver A said the facility conducted resident elopement drills and that she participated in one drill during the year 2020. Review of caregiver A's personnel record revealed a hire date of	A 032		

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A 032	Continued From page 5 Review of caregiver C's personnel record revealed a hire date of . Review of the facility's documented resident elopement drills that were provided by the administrator revealed that drills were conducted on . . . ., ... and . . . . . Caregiver A was not listed as a participant on any of them and caregiver C was listed only on . . . . . . At 4 p.m. on . . . . . the administrator confirmed the findings and was unable to provide additional documentation. Class III	A 032		
A 084 SS=D	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of	A 084		

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A 084	Continued From page 6 taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, , dosage forms, and , , and dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with syringes that are	A 084		

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A 084	Continued From page 7	A 084		

prefilled with the proper dosage by a pharmacist and , that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection;
i. Assist with ;
j. Use a to perform testing;
k. Assist residents with and continuous positive airway pressure (CPAP) devices, excluding the titration of the levels;
l. Apply and remove stockings and hosiery;
m. Placement and removal of bags, excluding the removal of the or manipulation of the site; and,
n. Measurement of , rate, temperature, and , rate.
(c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online.
(d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of

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A 084	Continued From page 8 medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training This Statute or Rule is not met as evidenced by: Based on personnel record review, Medication Observation Record (MOR) review and interview, the facility did not ensure that 1 of 4 sampled unlicensed staff (A), who provided assistance with the resident's medications received the initial 6 hours training in providing assistance with self-administered medications and safe medication practices in an Assisted Living Facility (ALF). Findings: Personnel record review for staff A, an unlicensed staff who assist with the self-administrator of medication, revealed there was a certificate for 2 hours of assisting with medication. There was no documentation to confirm she had received the initial 6 hours training in providing assistance with self-administered medications and safe medication practices in an ALF. On at 4 PM, the administrator said he could not provide evidence of 6-hour initial medication training. Class III	A 084		

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A 085 SS=D	59A-36.011(7) FAC Training - Nutrition & Food Service (7) NUTRITION AND FOOD SERVICE. The administrator or person designated by the administrator as responsible for the facility's food service and the day-to-day supervision of food service staff must obtain, annually, a minimum of 2 hours continuing education in topics pertinent to nutrition and food service in an assisted living facility. This requirement does not apply to administrators and designees who are exempt from training requirements under paragraph 59A-36.012(1)(b). A certified food manager, licensed dietician, registered dietary technician or health department sanitarian is qualified to train assisted living facility staff in nutrition and food service. This Statute or Rule is not met as evidenced by: Based on review of training certificates and interview, the staff, who was responsible for the facility's food service, did not have evidence to confirm a minimum of 2 hours continuing education each year in topics pertinent to nutrition and food service in an Assisted Living Facility (ALF) that was provided by a certified food manager, licensed dietician, registered dietary technician or health department sanitarians. Findings: Review of the training certificates provided by the facility's food service manager who was responsible for the facility's food service, revealed he had no documentation to confirm that he had obtained a minimum of 2 hours continuing education each year in topics pertinent to nutrition and food service in an Assisted Living Facility (ALF) that was provided by a certified food	A 085		

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A 085	Continued From page 10 manager, licensed dietician, registered dietary technician or health department sanitarians. On at 4 PM, the food service manager confirmed the findings. Class III	A 085		
A 093 SS=B	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are incorporated by reference and available for review at: http://iom.edu/Activities/Nutrition/SummaryDRIs/~/media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%2014.pdf. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes.	A 093		

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A 093	Continued From page 11 (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in	A 093		

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A 093	Continued From page 12 the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of , the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on menu review and interview, the facility did not ensure that the regular and therapeutic menus as served were maintained for 6 months.	A 093		

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A 093	Continued From page 13 Findings: Review of the menu's posted in the dining room revealed they were not dated. The food service manager was asked to provide the last 6 months of dated menus as served. On on 1 PM, the facility's dietitian said the facility did not maintain the dated menus for 6 months as required. Class	A 093		
AE206 SS=D	59A-36.021(6) FAC ECC - Service Plans (6) SERVICE PLANS. (a) Before receiving services, the extended congregate care administrator or manager must develop a preliminary service plan that includes an assessment of whether the resident meets the facility's residency criteria, an appraisal of the resident's unique physical, , , and social needs and preferences, and an evaluation of the facility's ability to meet the resident's needs. (b) Within 14 days of receiving services, the extended congregate care administrator or manager must coordinate the development of a written service plan that takes into account the resident's health assessment obtained pursuant to subsection (6); the resident's unique physical, , , and social needs and preferences; and how the facility will meet the resident's needs including the following if required: 1. Health monitoring, 2. Assistance with personal care services, 3. Nursing services,	AE206		

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	AL11911328	A. BUILDING: _____ B. WING _____	06/09/2021

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WESTMINSTER TOWERS	70 WEST LUCERNE CIRCLE ORLANDO, FL 32801

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AE206	Continued From page 14 4. Supervision, 5. Special diets, 6. Ancillary services, 7. The provision of other services such as transportation and supportive services; and, 8. The manner of service provision, and identification of service providers, including family and friends, in keeping with resident preferences. (c) Pursuant to the definitions of "shared responsibility" and "managed risk" as provided in section 429.02, F.S., the service plan must be developed and agreed upon by the resident or the resident's representative or designee, surrogate, guardian, or attorney-in-fact, and must reflect the responsibility and right of the resident to consider options and assume risks when making choices pertaining to the resident's service needs and preferences. (d) The service plan must be reviewed and updated quarterly to reflect any changes in the manner of service provision, accommodate any changes in the resident's physical or mental status, or pursuant to recommendations for modifications in the resident's care as documented in the nursing assessment. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to, within 14 days of 1 of 1 sampled resident receiving an Extended Congregate Care (ECC) service, coordinate the development of a written service plan that takes into account the resident's health assessment; the resident's unique physical, , , , and social needs and preferences; and how the facility will meet the resident's needs (#7.) Findings: Review of the facility's license revealed it	AE206		

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AE206	Continued From page 15 contained an ECC designation. At 9:45 a.m. on [redacted] the nursing director said there were no residents who received an ECC service. At 10:26 a.m. on [redacted] resident #7 was seen sitting in a chair in her room. She wore stockings covered by [redacted] wraps on both of her [redacted] that extended from her [redacted] to her [redacted]. She said she wore them because she had Lymphedema and that the facility nurses applied them every morning and she removed them herself each night. Review of resident #7's 1823 health assessment form that was dated [redacted] revealed the resident had a diagnoses of Lymphedema, [redacted] and [redacted] ([redacted]). A health care provider's order that was dated [redacted] instructed to apply Lymphedema wraps every morning to the resident's lower [redacted]. Review of the resident's [redacted] and [redacted] medication records revealed an entry to apply the wraps every morning and was signed each day by the facility's nurses. Review of the resident's record revealed it did not contain an ECC service plan, nursing monthly assessments and nursing progress notes. At 1:54 p.m. on [redacted] nurse E, who identified herself as both the ECC supervisor and registered nurse, said she did not know the facility's nurses were applying [redacted] wraps to resident #7. In addition, she said when a resident received an ECC service, she was responsible for	AE206		

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AE206	Continued From page 16 developing a service plan and conducting monthly nursing assessments and the facility nurses were responsible for documenting nursing progress notes. At 2:15 p.m. on nurse E provided a health care provider's order that was dated . . . . . , the day of the survey, that instructed to assist with Farrow wraps to . . . . . lower extremities each morning and wraps to be removed by resident at bedtime daily for Lymphedema maintenance. She then said the order dated was written wrong by the health care provider and that the wraps worn by the resident were not Lymphedema wraps but were Farrow wraps and therefore, she did not believe it was an ECC service. Farrow wraps are the brand name of wraps used in the treatment of Lymphedema. During the interview nurse E also said the wraps were in fact and therefore, an ECC service was not being provided. When asked by the agency representative why then were only the facility nurses and not the unlicensed caregivers permitted to apply the wraps, she said because it was not in the practice act for the caregivers and that the nurses had to assess the resident's . Class III	AE206		
AE208 SS=D	59A-36.021(8) FAC 429.07 (3)(b)3, FS ECC - Records 59A-36.021(8) RECORDS. (8) RECORDS. In addition to the records required in rule 59A-36.015, F.A.C., a facility providing extended congregate care services must maintain the following: (a) The service plans for each resident receiving extended congregate care services;	AE208		

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AE208	Continued From page 17 (b) The nursing progress notes for each resident receiving nursing services; (c) Nursing assessments; and, (d) The facility's extended congregate care policies and procedures. 429.07 (3)(b), FS 3. A facility that is licensed to provide extended congregate care services shall maintain a written progress report on each person who receives such nursing services from the facility's staff which describes the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to maintain monthly nursing assessments and written progress notes that described the type, amount, duration, scope, and outcome of services that were rendered and the general status of the resident's health for 1 of 1 sampled resident who received an ECC service (#7). Findings: Review of the facility's license revealed it contained an ECC designation. At 9:45 a.m. on the nursing director said there were no residents who received an ECC service. At 10:26 a.m. on resident #7 was seen sitting in a chair in her room. She wore stockings covered by , wraps on both of her . that extended from her to her . She said she wore them because she had	AE208		

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AE208	Continued From page 18 Lymphedema and that the facility nurses applied them every morning and she removed them herself each night. Review of resident #7's 1823 health assessment form that was dated revealed the resident had a diagnoses of Lymphedema, , , and (.) A health care provider's order that was dated instructed to apply Lymphedema wraps every morning to the resident's lower . Review of the resident's , and medication records revealed an entry to apply the wraps every morning and was signed each day by the facility's nurses. Review of the resident's record revealed it did not contain an ECC service plan, nursing monthly assessments and nursing progress notes. At 1:54 p.m. on nurse E, who identified herself as both the ECC supervisor and registered nurse, said she did not know the facility's nurses were applying wraps to resident #7. In addition, she said when a resident received an ECC service, she was responsible for developing a service plan and conducting monthly nursing assessments and the facility nurses were responsible for documenting nursing progress notes. At 2:15 p.m. on nurse E provided a health care provider's order that was dated , the day of the survey, that instructed to assist with Farrow wraps to lower extremities each morning and wraps to be removed by resident at bedtime daily for Lymphedema maintenance. She	AE208		

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AE208	Continued From page 19 then said the order dated was written wrong by the health care provider and that the wraps worn by the resident were not Lymphedema wraps but were Farrow wraps and therefore, she did not believe it was an ECC service. Farrow wraps are the brand name of wraps used in the treatment of Lymphedema. During the interview nurse E also said the wraps were in fact and therefore, an ECC service was not being provided. When asked by the agency representative why then were only the facility nurses and not the unlicensed caregivers permitted to apply the wraps, she said because it was not in the practice act for the caregivers and that the nurses had to assess the resident's . Class III	AE208		
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	CZ814		

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CZ814	Continued From page 20 criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [illegible] 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; [illegible]; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to obtain an updated Background Screening Clearinghouse (BGS) Employee Roster for 2 of 6 sampled staff (E & F) as required in ten (10) business days from date of employment. Findings: 1. Staff E's personnel record revealed a hire date of on [illegible]. The Level 2 BGS eligibility results dated [illegible]. According to the background screening roster for the facility staff E's employment ended on [illegible]. However, staff E was still currently employed at the facility as the Extended Congregate Care (ECC) Registered Nurse (RN). 2. Staff F's (food manager) personnel record revealed a hire date of [illegible]. The Level 2 BGS eligibility result was dated [illegible]. Staff F was not added on the BGS employee roster as required. (Photographic Evidence Obtained) On [illegible] at 4:30 PM, an interview with the	CZ814		

Agency for Health Care Administration

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CZ814	Continued From page 21 Administrator confirmed the finding. Unclassified	CZ814		