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
	AL11969175	A. BUILDING: _____ B. WING _____	08/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY COMFORT CARE II, INC	863 KUENZ PL OCOEE, FL 34761

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A re-licensure survey & generator monitoring was conducted at Country Comfort Care II, Inc. Assisted Living Facility on . The facility had deficiencies at the time of the visit.	A 000		
A 010 SS=D	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 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	A 010		

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A 010	Continued From page 1 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 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	A 010		

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A 010	Continued From page 2 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 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	A 010		

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A 010	Continued From page 3 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: Based on resident record review, observation and interview, the facility failed to obtain a new AHCA Form 1823 Health Assessment for 1 of 3 sampled residents (#2) for continued residency after a	A 010		

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A 010	Continued From page 4 significant change. Findings: Resident #2's record review revealed admission date . The last 1823 Health Assessment dated documented medical history of , fainting spells, , and a risk. She needs assistance with Activities of Daily Living (ADLs) with ambulation & transferring, supervision in eating, and total care for bathing, , grooming & toileting. She needs assistance with self-administration of medications. (Photographic Evidence Obtained) The facility notes documented on at 3:45 AM, resident #2 rolled out of the bed and on the floor hitting her with no injury; 911 called & taken to hospital. The family and healthcare provider were notified. She returned to the facility on . On at 3 AM, resident #2 out of her bed again, no injury but 911 was called and taken to the hospital. The family and healthcare provider were notified. She returned to the facility on with orders of half rail hospital bed for safety. On at 12 PM (noon), observation of resident #2 eating her lunch meal independently. Caregiver staff A assisted resident #2 in her wheelchair to the table. On at 12:45 PM, an interview with resident #2 stated that she can still do for herself just need help sometimes, but she is not total	A 010		

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A 010	Continued From page 5 care with anything. On [redacted] at 2 PM, an interview with the Administrator confirmed the findings. Class III	A 010		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident ' s representative or designee of the need for health care services and must assist in making [redacted] for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following:	A 025		

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A 025	Continued From page 6 (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on resident record review and interview, the facility failed to maintain written facility notes for any updates and significant change in medical condition for 1 of 3 sampled residents (#1). Findings: Resident #1's record revealed admission date [redacted]. The last AHCA Form 1823 Health Assessment dated [redacted] documented medical history of [redacted], and	A 025		

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A 025	Continued From page 7 . . . . . He needs assistance with his Activities of Daily Living (ADLs) with ambulation, bathing, ..., toileting, and transferring. Supervision with eating and grooming. He needs assistance with self-administration of medications. A Hospice order dated to be admitted was found in the file, but no interdisciplinary care plan signed and dated by Administrator and family as required. Furthermore, there was no facility notes documented of the significant change and follow up update. (Photographic Evidence Obtained) On . . . . . at 2:30 PM, an interview with the Administrator confirmed the findings. The administrator also stated that resident #1 was being discharged tomorrow going home with family. Class III	A 025		
A 032 SS=D	59A-36.007(8) FAC Resident Care - Elopement Standards 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 032		

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A 032	Continued From page 8 (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 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,	A 032		

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A 032	Continued From page 9 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 facility documentation and interview, the facility failed to develop a written Elopement policies and procedures of how to respond to a resident eloping from the premises. Findings: On at 1:30 PM, reviewed facility's documentation and there was no written detailed elopement policies and procedures to include an immediate search of the facility & premises; how long to wait to call the local law enforcement agency; identification of staff responsibilities during the elopement and continued care of all the residents during the elopement. It was identified that resident #1 was an elopement risk resident on the dated , AHCA Form 1823 Health Assessment. The administrator provided me documentation of the elopement drills dates completed on & . On at 2:30 PM, an interview with the Administrator confirmed the findings. Class III	A 032		

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A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known ␣ the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on resident record review, Medication Observation Record (MORs), observation and interview, the facility failed to update and chart (missing) medications correctly to be given for 1	A 054		

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A 054	Continued From page 11 of 3 sampled residents (#1) who receives assistance with self-administration of medications. Findings: An observation on [redacted] at 10 AM, caregiver staff A was not able to complete the Medication Observation Pass due for resident #1's medication of [redacted] ER 25-100 milligram (mg) to be taken 4 times daily at 6 AM, 10 AM, 2 PM & 6 PM because he was out of the medication. On [redacted] at 10:02 AM, an interview with caregiver A stated that he had been out for a few days of this medication. She confirmed that she did not notify the Administrator, family, or pharmacy. On [redacted] at 12:45 PM, an interview with Administrator asking if she had notified the pharmacy and family about the [redacted] 25-100 mg ran out. Administrator answered no she did not because the family should have provided the facility with enough medication when he was admitted on [redacted]. Resident #1's record revealed admission date [redacted]. The last AHCA Form 1823 Health Assessment dated [redacted] documented medical history of [redacted] and [redacted]. He needs assistance with his Activities of Daily Living (ADLs) with ambulation, bathing, [redacted], toileting, and transferring. Supervision with eating and grooming. He needs assistance with self-administration of	A 054		

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A 054	Continued From page 12 medications. (Photographic Evidence Obtained) The Medication Observation Record (MORs) for documented that he had not had his / ER 25-100mg since . He had been out of this medication for 3 days. There was no documented of reason on of the MORs. (Photographic Evidence Obtained) In further review, an order from the healthcare provider found for / ER 25-100mg dated to be taken at 6 AM, 10 AM, 2 PM & 6 PM but in addition on the MORs there was other medications had run out and had not been taken by resident #1 as follows below: 1. , 10 mg to be taken 1 tablet by once daily, last time taken on and last marked on MORs. No reason why documented on of the MORs. 2. 1 mg to be taken 1 tablet by once daily, missed dose on , & with no reason why on of MORs. 3. , 200 mg to be taken 1 and tablet by at bedtime, missed dose on , , , , , , , , , & with no reason why on the of MORs. 4.Tumeric 500 mg to be taken 2 capsules (1000 mg) by once daily, missed dose on	A 054		

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A 054	Continued From page 13 ..... , ... with no reason why on the of MORs. 5. C 1000 mg to be taken 1 tablet by ... once daily, missed dose on ..... & with no reason why on the of MORs. 6. ..... 40 mg to be taken 1 tablet by in the evening, missed dose on , ... , ... , ... , ... , ... , ... , ... & ..... with no reason why on of MORs. 7. 10 mg to be taken 1 tablet by ... once daily, missed dose on ..... & with no reason why on of MORs. (Photographic Evidence Obtained) On at 2:30 PM, an interview with the Administrator confirmed the findings. The administrator also stated that resident #1 was being discharged tomorrow ..... going home with family. Class III	A 054		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with chapters 465 and 499, F.S., and rule 64B16-28.108, F.A.C. If a customized patient	A 056		

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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
A 056	Continued From page 14 medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record.	A 056		

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	AL11969175	A. BUILDING: _____ B. WING _____	08/24/2021

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A 056	Continued From page 15 (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to section 465.0276(5), F.S., and rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on resident record review, Medication Observation Record (MORs) and interview, the	A 056		

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A 056	Continued From page 16 facility failed to get an order from the healthcare provider for changes with labeling the directions of use of medications for 1 of 3 sampled resident (#1) that needs assistance with self-administration of medications. Findings: Resident #1's record revealed admission date . The last AHCA Form 1823 Health Assessment dated documented medical history of , , , 's , , and . He needs assistance with his Activities of Daily Living (ADLs) with ambulation, bathing, , toileting, and transferring. Supervision with eating and grooming. He needs assistance with self-administration of medications. (Photographic Evidence Obtained) The Medication Observation Record (MORs) for had handwritten labeling of direction for use of medication from an unknown origin and not ordered by the physician indicating the direction of medications listed below: 1. inhaler 0.083% solution to be administer one vial via by every 6 hours. It was written from unknown origin "resident self-administers". There was no documented evidence of an order found in the file written by the physician to self-administer this medication. 2. Dupixent 300 milligram (mg)/2 milliliters (ml) to be injected , every month. It was written in from unknown origin "resident/family	A 056		

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A 056	Continued From page 17 self-administers". There was no documented evidence of an order found in the file written by the physician to self/family administer medication. 3. . . . 40 mg/0.8 ml to be injected , every two weeks. It was written in from unknown origin "resident/family self-administers". There was no documented evidence of an order found in the file written by the physician to self/family administer medication. 4. Wixela Diskus 500/500 mcg to be inhaled 1 puff by . . . once daily. It was written in from unknown origin "resident self-administers". There was no documented evidence of an order found in the file written by the physician to self-administer. 5. , . . . 2% . . . . . to apply to affected area every 12 hours. It was written in from unknown origin "resident self-administer". There was no documented evidence of an order found in the file written by the physician to self-administer. (Photographic Evidence Obtained) On at 2:30 PM, an interview with the Administrator confirmed the findings. The administrator also stated that resident #1 was being discharged tomorrow . . . . . going home with family. Class III	A 056		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment,	A 078		

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A 078	Continued From page 18 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. 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	A 078		

Agency for Health Care Administration

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A 078	Continued From page 19 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 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 personnel record review and interview, the facility failed to obtain annual freedom of communicable _____ statement from the healthcare provider for 2 of 3 sampled staff (A & B) as required. Findings: Staff A's personnel record review revealed a hire date . The last , dated _____ and last communicable _____ statement dated (last year) was found but there was no documented evidence of the 2021 freedom of communicable statement by a healthcare provider.	A 078		

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A 078	Continued From page 20 Staff B's personnel record review revealed a hire date of . The last , dated and last communicable statement dated (last year) was found but there was no documented evidence of the 2021 freedom of communicable statement by a healthcare provider. On at 2:30 PM, an interview with the Administrator confirmed the findings. Class III	A 078		
A 091 SS=D	59A-36.011(12) FAC Training - Documentation & Monitoring (12) TRAINING DOCUMENTATION AND MONITORING. (a) Except as otherwise noted, certificates, or copies of certificates, of any training required by this rule must be documented in the facility's personnel files. The documentation must include the following: 1. The title of the training program, 2. The subject matter of the training program, 3. The training program agenda, 4. The number of hours of the training program, 5. The trainee's name, dates of participation, and location of the training program, 6. The training provider's name, dated signature and credentials, and professional license number, if applicable. (b) Upon successful completion of training pursuant to this rule, the training provider must issue a certificate to the trainee as specified in this rule. (c) The facility must provide the Department of Elder Affairs and the Agency for Health Care Administration with training documentation and	A 091		

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A 091	Continued From page 21 training certificates for review, as requested. The department and agency reserve the right to attend and monitor all facility in-service training, which is intended to meet regulatory requirements. This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to include all topics for the required 2-hours pre-service orientation training for 2 of 3 sampled staff (A & B). Findings: 1. Staff A's personnel record review revealed a hire date of . A two-hour preservice orientation training was completed & signed on but missing documented topics of facility type and resident rights. (Photographic Evidence Obtained) 2. Staff B's personnel record review revealed a hire date of . A two-hour preservice orientation training was completed & signed on but documented topics of facility type and residents' rights. (Photographic Evidence Obtained) On at 2:30 PM, an interview with the Administrator confirmed the findings. Class III	A 091		