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
	AL11967024	A. BUILDING: _____ B. WING _____	12/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA GRANDE BELLE	5898 ORCHARD POND ROAD TALLAHASSEE, FL 32303

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A 000	Initial Comments An unannounced complaint investigation (complaint number 2021016732) was conducted at La Grande Belle on . Additional evidence gathering continued offsite through . The facility had deficiencies at the time of the survey. The facility census was 5 at the time of the visit. The following Class I deficiencies were identified on . A0025 Class I: Failure to ensure adequate supervision for 2 of 5 residents (Resident #1 and #2) including maintaining a general awareness of the residents' whereabouts during the 3rd shift to prevent for 1 of 1 resident (Resident #1). This failure placed 4 of 5 residents (Resident #1, #3, #4, #5) at the facility at risk of assault. A0030 Class I: Failure to honor resident rights by failing to provide a safe living environment free from ( ) for 1 of 5 residents (Resident #1) sampled for . The facility also failed to demonstrate that the grievance policy/procedure was implemented upon receipt of complaint of assault from Resident #1. A0077 Class I: The facility's Administrator who is responsible for operation of the facility failed to ensure the provision of appropriate care and safety to 5 of 5 residents (Resident #1, #2, #3, #4, #5) . The Administrator failed to ensure: (1) Residents were properly supervised to ensure client safety. (2) The provision of appropriate care to all residents by failing to follow the facility's policy and procedure for , Neglect, and , of Residents and thoroughly	A 000		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 000	Continued From page 1 investgate allegations of (. . . . .) . . . . . reported by Resident #1. (3) Residents were inappropriately supervised during the 3rd shift, leaving 1 of 5 residents (Resident #1) unprotected from . . . . (4) Residents were in a safe environment free of hazards by failing to ensure animals were properly restrained. (5) An adverse incident was reported for an incident which resulted in law enforcement responding to the facility to investigate an incident of assault related to the allegation that Resident #1 was . . . . . , assaulted by Resident #2. (6) 1 of 5 employees (Staff D) had an eligible level 2 background screening. (7) 1 of 5 employees (Staff C) completed an Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008 and retained the form in the employee's personnel record.	A 000		
A 025 SS=J	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 . . . . . or . . . . . or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such . . . . . or . . . . . 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 . . . . . for the necessary care and services to treat the condition. If the resident does not have a	A 025		

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A 025	Continued From page 2 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 Resident Care Standards. 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) 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.	A 025		

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A 025	Continued From page 3 This Statute or Rule is not met as evidenced by: Based on resident, staff and third party interviews and resident record and facility policy reviews, the facility failed to ensure adequate supervision for 2 of 5 residents (Resident #1 and #2) including maintaining a general awareness of the residents' whereabouts during the 3rd shift to prevent . . . . . for 1 of 1 resident (Resident #1). This failure placed 4 of 5 residents (Resident #1, #3, #4, #5) at the facility at risk of . . . . assault. The facility's failure to appropriately supervise residents to prevent and maintain a general awareness of residents' whereabouts during the 3rd shift resulted in a Class I deficiency. These failures had the potential to affect all 5 of the facility's residents. The findings include: On at 10:25 AM, an interview was conducted with Resident #1 who reported residing in the facility for two years. When asked about the alleged . . . . assault, Resident #1 reported that, prior to the incident, he had informed the facility Administrator of numerous occasions where he woke up during the night hours to find Resident #2 standing over his bed. "I thought he was looking for cigarettes or something," Resident #1 added. Resident #1 continued, "I told [Administrator] several times that he (Resident #2) would come into my room at night. He would stand just far enough away where I couldn't get my . . . . on him. This really started freaking me out. I yell out every time he comes into my room at night, and all the staff do is go in the room (staff room for overnight) at 8:00 PM and they don't come out." He went on to state he resulted to beating on the wall from	A 025		

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A 025	Continued From page 4	A 025		

bed to get staffs' attention when Resident #2 entered his room, but no staff ever responded. He stated he asked the Administrator if he had seen Resident #2 go into his room at night and the Administrator stated the cameras do not show the resident rooms, but also never looked at the video to verify Resident #2 was coming into his room at night. Resident #1 went on to explain that Resident #2 assaulted him sometime before Thanksgiving. He was unable to recall the exact date. He stated he waited several days to report the details about the assault because he was "embarrassed and humiliated" that it occurred. Resident #1 stated he woke up and realized Resident #2 "had both in his (Resident #1's) boxer shorts, fondling his private parts, and Resident #2 was naked from the waist down. He stated he began yelling at the time and banging on the wall, but no staff ever responded. He stated he was able to kick Resident #2 in the and get him off of him with his one as he has a below-the- on his right . He stated, "Resident #2 went two steps after I kicked him and stood there with an and stared at me while he until he was done." Resident #1 further stated, "When I got out of bed and into my wheelchair, Resident #2 ran out the door and returned to his own room." Resident #1 reported thinking maybe Resident #2 was not in his right mind when this occurred, so he asked Resident #2 the morning after the incident if he knew or remembered what he had done to him the night before. According to Resident #1, Resident #2 acknowledged that he knew what he had done.

Resident #1 stated when the incident occurred, he was hoping it was a bad dream or a nightmare. After several days he stated he told Staff F, caretaker (no longer employed at facility), who advised Resident #1 that an incident report

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A 025	Continued From page 5	A 025		

would be completed, and the Administrator would be contacted. He stated Staff F spoke with Resident #2 and the resident did not deny the incident occurred. She also made Resident #2 apologize to him (Resident #1). Resident #1 stated outside of this, "nothing else had been done". He stated he attempted to contact the Administrator repeatedly days following the incident, but the Administrator "does not answer my calls and his voicemail is full. When he does answer the phone, he hangs up on me." He stated he was finally able to tell the Administrator about the incident when he came into town. Resident #1 stated, "When I asked him (Administrator) what was going to be done about Resident #2, he acted like he did not know what I was talking about. He (Administrator) stated Staff F never called him and told him about the assault." Resident #1 stated, "the Administrator made me and Resident #2 come and speak with him about the incident in his office." Resident #1 reported that during the meeting, Resident #2 did not deny the incident occurred and said he thought maybe he was having a ." Resident #1 stated prior to the incident, his door would not lock because his doorknob was broken. According to Resident #1, the Administrator purchased a new doorknob with a lock only after another incident of Resident #2 coming into his room on another night after the assault occurred. Resident #1 stated he had to install the doorknob himself. When asked how this incident has affected him, he stated, "Now I don't sleep, i have dreams of Resident #2 coming in my room and standing over my bed smiling, and I cannot move or speak. I scream at him to get out of my room, but he just moves a couple steps and I cannot move in my dream, I cannot get away from him. I think about his being all over me and it makes me

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sick. I think his coming in my room all those times prior to the incident was him setting up to do what he did. This has been a terrible ordeal for me because I cannot see anything being done."
Resident #1 stated, "when my case manager told me to call the police and report this, the Administrator heard I was going to do this and called the police before I could." Resident #1 stated he reported this incident to his case manager, and she reached out to the Administrator and told him this was being handled. Resident #1 stated, "I'm also worried that he may be doing this to someone else in the facility. It's just weird that he would pick me and do this to me. I believe he must have something in his past. I was assured that an incident report would be filed. I now lock my door and I am so scared he's coming in my room that I check the closet after I return to my room to make sure he's not in my room. Often my mind races trying to remember if I locked the door or turned on the light in order to keep him out and make sure I know he's out." Resident #1 reported he does not feel safe at the facility and feels that he is not being protected. He again stated that night staff do not come out of their bedroom during their shift. He stated there have been over 10 incidents of him in the hallway yelling about Resident #2 coming into his room.
Resident #1 stated, "A detective came out on . . . . . to investigate the allegation, but the detective basically told me that there was nothing they could do because it was my word against his (Resident #2)." Resident #1 reported that when the detective came to the facility, the Administrator was also at the facility. Resident #1 reported he pointed out the facility had video cameras to the detective, but the Administrator informed them both that he controlled the cameras and there was no footage since it had

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A 025	Continued From page 7 been over 30 days since the [redacted] assault incident. According to Resident #1, the Administrator stated recordings are only available for 30 days. On [redacted] at 10:32 AM an interview was conducted with Resident #2, the alleged [redacted]. Resident #2 revealed he had been living at the facility about a year. When the surveyor asked Resident #2 about the alleged [redacted] assault to Resident #1, Resident #2 stated that he was "having a [redacted] and does not remember what happened." He stated that he does not remember Resident #1 approaching him and asking him anything about the incident. Resident #2 stated that no staff had talked with him about the incident that he could remember. He also stated he does not have any memory issues. On [redacted] at 10:36 AM, an interview was conducted with Staff B, lead staff and caretaker, who reported that Resident #1 informed her the day after the incident that Resident #2 had come into his room and tried to [redacted] on him. Staff B stated Resident #1 told her that he screamed, and nobody came to check on him. She also reported that Resident #1 said he told Resident #2 to get out of his room and he did. Staff B stated she told Resident #1 that he needed to inform the Administrator of the incident. Staff B stated to the surveyor that she did not do anything, instead "stayed out of it and allowed Resident #1 to report the incident himself to the Administrator." She also confirmed that no one at the facility called the police to her knowledge although the police came out the other day ( ) to investigate. Staff B reported Resident #1 and the Administrator were involved in the meeting with the officer. She stated that	A 025		

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A 025	Continued From page 8 staff have received training on . . . . . , neglect, and . , . She also stated she has "worked the overnight shift on occasion and staff are allowed to sleep at night due to there not being that many residents." She stated, "about 12 AM staff will go lay down in the staff bedroom, which is the room located directly across from Resident #1's room." On at 10:43 AM and on at 12:30 PM, telephone interviews were conducted with Staff C, a caretaker, who reported that she was not at the facility the night of the incident between Resident #1 and Resident #2. She stated she worked on the weekend. She stated Resident #1 told her about the incident when she reported for her weekend shift but could not recall the exact date the incident occurred. She stated Resident #1 reported the incident to her several days after the incident happened. She stated Resident #1 reported to her that Resident #2 came into his bedroom and tried to , assault him. Staff C stated she passed the information along to the Administrator who owns the facility. She also stated she believed the Administrator was working that night. She again confirmed that she reported the incident immediately to the Administrator. Staff C was unable to provide an exact date that Resident #1 reported the incident to her. On at 11:20 AM, a telephone interview was conducted with the case manager for Resident #1. The case manager stated she was informed of the incident on . . . . . when the resident contacted her about it. She stated Resident #1 said he was in bed and woke up with a resident on him trying to , assault him. On after receiving the complaint, she contacted her supervisor who contacted the	A 025		

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A 025	Continued From page 9 police and Adult Protective Services because no one from the facility had reported this incident to any authorities. The case manager reported the detective stated he would be coming to the facility on ..... to speak to Resident #1 but did not go until ..... She stated Resident #1 informed her that he did not feel safe and wanted out of the facility. She also reported she advised Resident #1 to report the incident to the Agency for Health Care Administration's Complaint Unit based on advice from her supervisor. The case manager stated, "I've been trying to find another placement for him. I emailed him a list of apartments in the area. I also offered another assisted living facility (ALF) in the area, but he's fearful of living in an ALF since this incident." The case manager stated, "I've been with [name of agency] for 9 years and this is mind boggling. He's been so ..... I cannot believe how the Administrator is acting like this is nothing." On at 12:55 PM, a telephone interview was conducted with the Administrator who reported he had not received any grievances from any residents or filed any adverse incident reports. The Administrator stated that when the incident was brought to his attention he talked with both residents and, "it was a case of he said, he said." The Administrator stated that he did not conduct a formal investigation of the allegations, or review any video because the cameras do not show what happens in the resident's room. On at 9:30 AM, a telephone interview was conducted with Staff D who reported she had only worked at the facility for a couple months. Staff D stated she was not at the facility at the time the incident occurred but confirmed Resident #1 and Resident #2 got into an altercation about the incident. She stated she asked Resident #2	A 025		

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about the incident involving Resident #1 and, "he admitted to doing that to Resident #1." Staff D stated she went over the rules about touching people with Resident #2 and he expressed regret about it. Staff D stated she was at the facility working on the day that law enforcement arrived to investigate but was never asked about the incident. When asked how she supervises the residents while working the night shift, she stated she "can keep an _ on them overnight on the cameras from the staff bedroom" but stated she had not seen Resident #2 enter Resident #1's room.

On at 3:48 PM, a follow-up telephone interview was conducted with the Administrator. When asked about the process for reviewing cameras, he stated, "I use the cameras so I can see what is going on in the facility from a distance through my telephone. I have cameras in the facility, there is a camera in the main hall facing the bathroom so I can see the two resident doors, but not inside the resident rooms. There is one in the office, one in the main front area, laundry room and pantry area in the kitchen." When asked how long the footage is accessible, he stated, "it records over itself every 30 days to save drive space so there is no footage from the day of the incident which took place in ." When asked who had access and if staff are supposed to be monitoring the cameras, he stated "staff can monitor the cameras overnight and they are allowed to sleep at night since we only have 5 residents." When asked about when the incident occurred and when Resident #1 reported this, the Administrator stated, "Resident #1 reported this about seven days later after the incident. He told Staff C and informed her of what happened." The Administrator stated he believed Resident #1

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A 025	Continued From page 11 "was just trying to get Resident #2 kicked out of the facility. He's had problems with every roommate he's ever had." When asked if he had any documentation to confirm Resident #1 had the behavior issues he was describing, or was known for reporting false allegations, the Administrator admitted he did not. He also stated he did not report the incident because Resident #1 did not want to report it. On . . . . at 4:13 PM, a telephone interview was conducted with the responding Law Enforcement Officer (LEO). The LEO stated "it took several days for Resident #1 to report the assault. He did not report it initially, because he thought the offending resident would be discharged from the facility but decided to contact law enforcement after he figured out that Resident #2 was not going to be discharged from the facility." The LEO stated he took the initial report, "then it goes to detectives to be followed up on." He also was not sure which detective would be assigned the case, but it would be someone in violent crimes unit. The LEO stated, "staff confirmed with him that Resident #2 creeps around the house at night" and he attempted to contact the staff person who was onsite (Staff D) but was unable to reach. The LEO reported Resident #1 stated he was screaming out so he cannot understand how staff could not hear the resident yelling out. The LEO added, "The facility did not put a lock on Resident #1's door until after Resident #2 again came into Resident #1's room in an incident after the assault incident." A review of Resident #1 and Resident #2's records revealed there were no records or documentation related to the above incidents. Resident health records contained the resident health assessment (form 1823), list of	A 025		

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A 025	Continued From page 12 medications, insurance information, etc. However, the records contained only blank "resident observation forms". Class I	A 025		
A 030 SS=J	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; . . . . , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- . . or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents	A 030		

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A 030	Continued From page 13 and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where	A 030		

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A 030	Continued From page 14 residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from [redacted] and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as	A 030		

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A 030	Continued From page 15 provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with	A 030		

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A 030	Continued From page 16	A 030		

relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.
(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.
(2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility

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A 030	Continued From page 17 must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on resident, staff and third party interviews, and resident record reviews, the facility failed to honor resident rights by failing to provide a safe living environment free from ( ) for 1 of 5 residents (Resident #1) reviewed for . The facility also failed to demonstrate that the grievance policy/procedure was implemented upon receipt of complaint of assault from Resident #1.	A 030		

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A 030	Continued From page 18 The facility's failure to provide a safe living environment free from ( ) for 1 of 5 residents (Resident #1) and ensure complaints/allegations of assault were thoroughly investigated resulted in a Class I deficiency. These failures had the potential to affect all 5 of the facility's residents. The findings include: Review of the facility's undated policy Reporting of Neglect & , revealed: "All staff, residents, guests and government agencies alike are to report any resident's rights being violated." Procedure: 1. The number to report , neglect & , is 1.800.96. . 2. Immediately contact the administrator or manager of incident. 3. Follow-up with Department of Children and Families as to the outcome of the report. Review of the undated facility policy for resident grievances revealed: "Residents of La Grande Belle Estates, ALF have a Resident's Council monthly to discuss their grievances or concerns. This is where residents, staff, and administrator and invited family members make suggestions and/or resolve issues." The procedure is as follows: "a form is to be completed and placed in the suggestions box, located in a central area, known by all resident's, a follow-up will be made by an immediate response to issue if necessary or at the resident's council, held monthly, a review of this form is collected daily to identify and or address, a resident does not have to identify his or herself, a resolution note will be made at council meeting, resident council suggestions forms will be kept in facility file for review." On at 10:25 AM, an interview was	A 030		

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A 030	Continued From page 19 conducted with Resident #1 who reported residing in the facility for two years. When asked about the alleged . . . assault, Resident #1 reported that, prior to the incident, he had informed the facility Administrator of numerous occasions where he woke up during the night hours to find Resident #2 standing over his bed. "I thought he was looking for cigarettes or something," Resident #1 added. Resident #1 continued, "I told [Administrator] several times that he (Resident #2) would come into my room at night. He would stand just far enough away where I couldn't get my . . . on him. This really started freaking me out. I yell out every time he comes into my room at night, and all the staff do is go in the room (staff room for overnight) at 8:00 PM and they don't come out." He went on to state he resulted to beating on the wall from bed to get staffs' attention when Resident #2 entered his room, but no staff ever responded. He stated he asked the Administrator if he had seen Resident #2 go into his room at night and the Administrator stated the cameras do not show the resident rooms, but also never looked at the video to verify Resident #2 was coming into his room at night. Resident #1 went on to explain that Resident #2 , assaulted him sometime before Thanksgiving. He was unable to recall the exact date. He stated he waited several days to report the details about the assault because he was "embarrassed and humiliated" that it occurred. Resident #1 stated he woke up and realized Resident #2 "had both . . . in his (Resident #1's) boxer shorts, fondling his private parts, and Resident #2 was naked from the waist down. He stated he began yelling at the time and banging on the wall, but no staff ever responded. He stated he was able to kick Resident #2 in the . . . and get him off of him with his one , as he has a below-the- . . , . . on his	A 030		

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A 030	Continued From page 20 right [illegible]. He stated, "Resident #2 went [illegible] two steps after I kicked him and stood there with an [illegible] and stared at me while he [illegible] until he was done." Resident #1 further stated, "When I got out of bed and into my wheelchair, Resident #2 ran out the door and returned to his own room." Resident #1 reported thinking maybe Resident #2 was not in his right mind when this occurred, so he asked Resident #2 the morning after the incident if he knew or remembered what he had done to him the night before. According to Resident #1, Resident #2 acknowledged that he knew what he had done. Resident #1 stated when the incident occurred, he was hoping it was a bad dream or a nightmare. After several days he stated he told Staff F, caretaker (no longer employed at facility), who advised Resident #1 that an incident report would be completed, and the Administrator would be contacted. He stated Staff F spoke with Resident #2 and the resident did not deny the incident occurred. She also made Resident #2 apologize to him (Resident #1). Resident #1 stated outside of this, "nothing else had been done". He stated he attempted to contact the Administrator repeatedly days following the incident, but the Administrator "does not answer my calls and his voicemail is full. When he does answer the phone, he hangs up on me." He stated he was finally able to tell the Administrator about the incident when he came [illegible] into town. Resident #1 stated, "When I asked him (Administrator) what was going to be done about Resident #2, he acted like he did not know what I was talking about. He (Administrator) stated Staff F never called him and told him about the assault." Resident #1 stated, "the Administrator made me and Resident #2 come and speak with him about the incident in his office." Resident #1 reported that during the meeting, Resident #2 did	A 030		

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A 030	Continued From page 21	A 030		

not deny the incident occurred and said he thought maybe he was having a ." Resident #1 stated prior to the incident, his door would not lock because his doorknob was broken. According to Resident #1, the Administrator purchased a new doorknob with a lock only after another incident of Resident #2 coming into his room on another night after the assault occurred. Resident #1 stated he had to install the doorknob himself. When asked how this incident has affected him, he stated, "Now I don't sleep, I have dreams of Resident #2 coming in my room and standing over my bed smiling, and I cannot move or speak. I scream at him to get out of my room, but he just moves a couple steps and I cannot move in my dream, I cannot get away from him. I think about his being all over me and it makes me sick. I think his coming in my room all those times prior to the incident was him setting up to do what he did. This has been a terrible ordeal for me because I cannot see anything being done." Resident #1 stated, "when my case manager told me to call the police and report this, the Administrator heard I was going to do this and called the police before I could." Resident #1 stated he reported this incident to his case manager, and she reached out to the Administrator and told him this was being handled. Resident #1 stated, "I'm also worried that he may be doing this to someone else in the facility. It's just weird that he would pick me and do this to me. I believe he must have something in his past. I was assured that an incident report would be filed. I now lock my door and I am so scared he's coming in my room that I check the closet after I return to my room to make sure he's not in my room. Often my mind races trying to remember if I locked the door or turned on the light in order to keep him out and make sure I

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A 030	Continued From page 22 know he's out." Resident #1 reported he does not feel safe at the facility and feels that he is not being protected. He again stated that night staff do not come out of their bedroom during their shift. He stated there have been over 10 incidents of him in the hallway yelling about Resident #2 coming into his room. Resident #1 stated, "A detective came out on . . . . to investigate the allegation, but the detective basically told me that there was nothing they could do because it was my word against his (Resident #2)." Resident #1 reported that when the detective came to the facility, the Administrator was also at the facility. Resident #1 reported he pointed out the facility had video cameras to the detective, but the Administrator informed them both that he controlled the cameras and there was no footage since it had been over 30 days since the . . . . assault incident. According to Resident #1, the Administrator stated recordings are only available for 30 days. On at 10:32 AM an interview was conducted with Resident #2, the alleged , ... Resident #2 revealed he had been living at the facility about a year. When the surveyor asked Resident #2 about the alleged . . . . assault to Resident #1, Resident #2 stated that he was "having a and does not remember what happened." He stated that he does not remember Resident #1 approaching him and asking him anything about the incident. Resident #2 stated that no staff had talked with him about the incident that he could remember. He also stated he does not have any memory issues. On at 10:36 AM, an interview was conducted with Staff B, lead staff and caretaker,	A 030		

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A 030	Continued From page 23 who reported that Resident #1 informed her the day after the incident that Resident #2 had come into his room and tried to [redacted] on him. Staff B stated Resident #1 told her that he screamed, and nobody came to check on him. She also reported that Resident #1 said he told Resident #2 to get out of his room and he did. Staff B stated she told Resident #1 that he needed to inform the Administrator of the incident. Staff B stated to the surveyor that she did not do anything, instead "stayed out of it and allowed Resident #1 to report the incident himself to the Administrator." She also confirmed that no one at the facility called the police to her knowledge although the police came out the other day ( ) to investigate. Staff B reported Resident #1 and the Administrator were involved in the meeting with the officer. She stated that staff have received training on [redacted], neglect, and [redacted]. She also stated she has "worked the overnight shift on occasion and staff are allowed to sleep at night due to there not being that many residents." She stated, "about 12 AM staff will go lay down in the staff bedroom, which is the room located directly across from Resident #1's room." On at 10:43AM and on at 12:30PM, telephone interviews were conducted with Staff C, a caretaker who reported that she was not at the facility the night of the incident between Resident #1 and Resident #2. She advised she worked on the weekend. She stated Resident #1 told her when she got there on the weekend for her shift but could not recall what the exact date was that the incident had occurred. She stated Resident #1 reported the incident to her several days after the incident happened. She stated that Resident #1 reported to her that Resident #2 came into his bedroom (Resident #1)	A 030		

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A 030	Continued From page 24 and tried to . . . . , assault him. Staff C states she passed the information along to the Administrator who owns the facility. She also stated she believes the Administrator was working that night. She again confirmed that she had reported the incident immediately to the Administrator. Staff C was unable to provide an exact date that Resident #1 had reported the incident to her. On . . . . at 11:20 AM, a telephone interview was conducted with the case manager for Resident #1. The case manager stated she was informed of the incident on when the resident contacted her about it. She stated Resident #1 said he was in bed and woke up with a resident on him trying to . . . . , assault him. On after receiving the complaint, she contacted her supervisor who contacted the police and Adult Protective Services because no one from the facility had reported this incident to any authorities. The case manager reported the detective stated he would be coming to the facility on to speak to Resident #1 but did not go until . . . . She stated Resident #1 informed her that he did not feel safe and wanted out of the facility. She also reported she advised Resident #1 to report the incident to the Agency for Health Care Administration's Complaint Unit based on advice from her supervisor. The case manager stated, "I've been trying to find another placement for him. I emailed him a list of apartments in the area. I also offered another assisted living facility (ALF) in the area, but he's fearful of living in an ALF since this incident." The case manager stated, "I've been with [name of agency] for 9 years and this is mind boggling. He's been so . I cannot believe how the Administrator is acting like this is nothing."	A 030		

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LA GRANDE BELLE	5898 ORCHARD POND ROAD TALLAHASSEE, FL 32303

(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 030	Continued From page 25 On ... ... at 12:55 PM, a telephone interview was conducted with the Administrator who reported he had not received any grievances from any residents or filed any adverse incident reports. The Administrator stated that when the incident was brought to his attention he talked with both residents and, "it was a case of he said, he said." The Administrator stated that he did not conduct a formal investigation of the allegations or review any video because the cameras do not show what happens in the resident's room. On ... ... at 9:30 AM, a telephone interview was conducted with Staff D who reported she had only worked at the facility for a couple months. Staff D stated she was not at the facility at the time the incident occurred but confirmed Resident #1 and Resident #2 got into an altercation about the incident. She stated she asked Resident #2 about the incident involving Resident #1 and, "he admitted to doing that to Resident #1." Staff D stated she went over the rules about touching people with Resident #2 and he expressed regret about it. Staff D stated she was at the facility working on the day that law enforcement arrived to investigate but was never asked about the incident. When asked how she supervises the residents while working the night shift, she stated she "can keep an _ on them overnight on the cameras from the staff bedroom" but stated she had not seen Resident #2 enter Resident #1's room. On at 3:48 PM, a follow-up telephone interview was conducted with the Administrator. When asked about the process for reviewing cameras, he stated, "I use the cameras so I can see what is going on in the facility from a distance through my telephone. I have cameras in the facility, there is a camera in the main hall facing	A 030		

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A 030	Continued From page 26	A 030		

the bathroom so I can see the two resident doors, but not inside the resident rooms. There is one in the office, one in the main front area, laundry room and pantry area in the kitchen." When asked how long the footage is accessible, he stated, "it records over itself every 30 days to save drive space so there is no footage from the day of the incident which took place in . . . . . ." When asked who had access and if staff are supposed to be monitoring the cameras, he stated "staff can monitor the cameras overnight and they are allowed to sleep at night since we only have 5 residents." When asked about when the incident occurred and when Resident #1 reported this, the Administrator stated, "Resident #1 reported this about seven days later after the incident. He told Staff C and informed her of what happened." The Administrator stated he believed Resident #1 "was just trying to get Resident #2 kicked out of the facility. He's had problems with every roommate he's ever had." When asked if he had any documentation to confirm Resident #1 had the behavior issues he was describing, or was known for reporting false allegations, the Administrator admitted he did not. He also stated he did not report the incident because Resident #1 did not want to report it.

On at 4:13 PM, a telephone interview was conducted with the responding Law Enforcement Officer (LEO). The LEO stated "it took several days for Resident #1 to report the assault. He did not report it initially, because he thought the offending resident would be discharged from the facility but decided to contact law enforcement after he figured out that Resident #2 was not going to be discharged from the facility." The LEO stated he took the initial report, "then it goes to detectives to be followed

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A 030	Continued From page 27	A 030		

up on." He also was not sure which detective would be assigned the case, but it would be someone in violent crimes unit. The LEO stated, "staff confirmed with him that Resident #2 creeps around the house at night" and he attempted to contact the staff person who was onsite (Staff D) but was unable to reach. The LEO reported Resident #1 stated he was screaming out so he cannot understand how staff could not hear the resident yelling out. The LEO added, "The facility did not put a lock on Resident #1's door until after Resident #2 again came into Resident #1's room in an incident after the assault incident."

A review of Resident #1 and Resident #2's records revealed there were no records or documentation related to the above incidents. Resident health records contained the resident health assessment (form 1823), list of medications, insurance information, etc. However, the records contained only blank "resident observation forms".

A review of the resident health assessment (form 1823) for Resident #1 (alleged victim) revealed the resident was admitted to the facility on . The medical history and diagnosis indicated disuse myopathy due to below-the- , . The form indicated in the Physical and Sensory Limitations section that Resident #1 required the use of a wheelchair for mobility. The form indicated the resident was alert and oriented to person, place, time, and situation in the or Behavioral Status section.

A review of the resident health assessment (form 1823) for for Resident #2 (alleged , ,) revealed the resident was admitted to the facility on . The medical history and diagnoses included

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A 030	Continued From page 28 ( ), type II, , , ( ) positive, , and tobacco use . The form indicated the resident was diagnosed with , and stable with medication use and , . Class I	A 030		
A 077 SS=J	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years.	A 077		

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A 077	Continued From page 29 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least [illegible]; 2. If employed on or after [illegible], have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to [illegible], are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the [illegible] of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not	A 077		

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A 077	Continued From page 30 to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator	A 077		

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A 077	Continued From page 31 form, AHCA Form 3180-1006, ... , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on resident, staff and third party interviews, review of facility policies and resident records, the facility's Administrator (who is responsible for operation of the facility) failed to ensure the provision of appropriate care and safety to 5 of 5 residents (Resident #1, #2, #3, #4, #5). The Administrator failed to ensure: 1. Residents were properly supervised to ensure client safety. 2. The provision of appropriate care to all residents by failing to follow the facility's policy and procedure for , Neglect, and , ... of Residents and thoroughly investigate allegations of . . . reported by Resident #1. 3. Residents were appropriately supervised during the 3rd shift, leaving 1 of 5 residents (Resident #1) unprotected from . 4. Residents were in a safe environment free of hazards by failing to ensure animals were properly restrained ensuring the safety of 5 of 5 residents from potential negative interaction with the improperly restrained dogs. 5. Adverse incident was reported for an incident which resulted in law enforcement responding to the facility to investigate an incident of . assault related to Resident #1 being . . . . , assaulted by Resident #2. 6. 1 of 5 employees (Staff D) had an eligible level 2 background screening.	A 077		

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A 077	Continued From page 32 7. 1 of 5 employees (Staff C) completed an Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008 and retained the form in the employee's personnel record. The Administrator's failure to ensure the provision of appropriate care and safety of 5 of 5 residents (Residents #1, #2, #3, #4, and #5) and the management of all staff resulted in a Class I deficiency. These failures had the potential to affect all 5 of the facility's residents. The findings include: Please refer to the following deficiencies cited on . . . . . : St- A- 0025- Resident Care- Supervision- Class I St- A- 0030- Resident Care- Rights & Facility Procedures- Class I St- A- 0152- Physical Plant- Safe Living Enviroment/Other- Class III St- A- 0165- Risk Management and Quality Assurrance- Class II St- C- Z815- Background Screening; Prohibited Offenses- Unclassified St-C- Z816- Background Screening- Compliance Attestation- Unclassified The facility also has outstanding deficiencies cited on . . . . . : St- A-0008- Admissions- Health Assessment- Class III St- A-0025- Resident Care-Supervision-II St- A-0077- Staffing Standards- Administrators- Class II St- A-0078- Staffing Standards-Staff- Class III	A 077		

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A 077	Continued From page 33 St- A-0079- Staffing Standards-Levels- Class II St- A-0081- Training- Staff In-Services- Class III St- A-0083- Training- First Aid and . . - Class II St- A-0084- Training-Assistance with Self Administration of Medication and Medication Management- Class III St- A-0090- Training- . . . . . -" Class III St- A-0093- Food Service-Dietary Standards- Class III St- A-0160- Records- Facility- Class III St- A-0200- Emergency Environmental Control- Class II St- A-L241- LMH- Records- Class III St- A-L243- LMH-Training-Class III St- C-Z813- Results of Screening & Notification In File- Unclassified St- C-Z814- Background Screening Clearinghouse- Unclassified St- C-Z816- Background Screening-Compliance Attestation- Unclassified St- C-Z830 - Emergency Management Planning - Class III Class I	A 077		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents	A 152		

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A 152	Continued From page 34 must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable [illegible] to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be [illegible] This Statute or Rule is not met as evidenced by: Based on observation, resident interview and interview with an animal control officer, the facility failed to ensure a safe environment free of hazards by failing to ensure animals were properly restrained ensuring the safety of 5 of 5 residents (Residents #1, #2, #3, #4 and #5) from potential negative interaction with the improperly restrained dogs. The findings include:	A 152		

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A 152	Continued From page 35 On ... at 10:30 AM, an interview with Resident #1 revealed he was concerned about "vicious" dogs being chained in the ... yard. Resident #1 stated, "These dogs stay out there on chains and have no human interaction except when they are fed. The Administrator had some guy come and feed them every day, but if they get off those chains, I'm afraid they will ." He further stated, "the dogs growl and bark at me when I am in the yard." On at 12:11 PM, an observation of the ... yard revealed two dogs, each chained to a doghouse, and another dog in a chain link fenced pen approximately 8ft. x 10ft. On at 3:00 PM, an Animal Control Officer interview revealed he thought the dogs looked healthy and had fresh hay, water and food, however, the owner of the dogs (Administrator) was in violation of the county ordinance against tethering dogs. An observation of the Animal Control Officer revealed a phone call was made to the Administrator in which the officer advised that the chained dogs was a violation of the ordinance and the officer would return in a week to ensure the dogs were no longer chained up in the yard. Class III	A 152		
A 165 SS=G	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality	A 165		

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A 165	Continued From page 36 assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident.	A 165		

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A 165	Continued From page 37 (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary	A 165		

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A 165	Continued From page 38 proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on resident and staff interviews and record reviews, the facility failed to report an adverse incident related to the alleged assault of Resident #1 by Resident # 2, which resulted in law enforcement responding to the facility for 1 of 1 adverse incident reviewed. The findings include: On at 10:25 AM, an interview was conducted with Resident #1 who reported residing in the facility for two years. When asked about the alleged assault, Resident #1 reported that, prior to the incident, he had informed the facility Administrator of numerous occasions where he woke up during the night hours to find Resident #2 standing over his bed. "I thought he was looking for cigarettes or something," Resident #1 added. Resident #1 continued, "I told [Administrator] several times that he (Resident #2) would come into my room at night. He would stand just far enough away where I couldn't get my on him. This really started freaking me out. I yell out every time he comes into my room at night, and all the staff do is go in the room (staff room for overnight) at 8:00 PM and they don't come out." He went on to state he resulted to beating on the wall from bed to get staffs' attention when Resident #2 entered his room, but no staff ever responded. He stated he asked the Administrator if he had seen Resident #2 go into his room at night and the Administrator stated the cameras do not show	A 165		

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the resident rooms, but also never looked at the video to verify Resident #2 was coming into his room at night. Resident #1 went on to explain that Resident #2 assaulted him sometime before Thanksgiving. He was unable to recall the exact date. He stated he waited several days to report the details about the assault because he was "embarrassed and humiliated" that it occurred. Resident #1 stated he woke up and realized Resident #2 "had both in his (Resident #1's) boxer shorts, fondling his private parts, and Resident #2 was naked from the waist down. He stated he began yelling at the time and banging on the wall, but no staff ever responded. He stated he was able to kick Resident #2 in the and get him off of him with his one as he has a below-the- on his right . He stated, "Resident #2 went two steps after I kicked him and stood there with an and stared at me while he until he was done." Resident #1 further stated, "When I got out of bed and into my wheelchair, Resident #2 ran out the door and returned to his own room." Resident #1 reported thinking maybe Resident #2 was not in his right mind when this occurred, so he asked Resident #2 the morning after the incident if he knew or remembered what he had done to him the night before. According to Resident #1, Resident #2 acknowledged that he knew what he had done.

Resident #1 stated when the incident occurred, he was hoping it was a bad dream or a nightmare. After several days he stated he told Staff F, caretaker (no longer employed at facility), who advised Resident #1 that an incident report would be completed, and the Administrator would be contacted. He stated Staff F spoke with Resident #2 and the resident did not deny the incident occurred. She also made Resident #2 apologize to him (Resident #1). Resident #1

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stated outside of this, "nothing else had been done". He stated he attempted to contact the Administrator repeatedly days following the incident, but the Administrator "does not answer my calls and his voicemail is full. When he does answer the phone, he hangs up on me." He stated he was finally able to tell the Administrator about the incident when he came into town. Resident #1 stated, "When I asked him (Administrator) what was going to be done about Resident #2, he acted like he did not know what I was talking about. He (Administrator) stated Staff F never called him and told him about the . . . assault." Resident #1 stated, "the Administrator made me and Resident #2 come and speak with him about the incident in his office." Resident #1 reported that during the meeting, Resident #2 did not deny the incident occurred and said he thought maybe he was having a . . . . . ." Resident #1 stated prior to the incident, his door would not lock because his doorknob was broken. According to Resident #1, the Administrator purchased a new doorknob with a lock only after another incident of Resident #2 coming into his room on another night after the assault occurred. Resident #1 stated he had to install the doorknob himself. When asked how this incident has affected him, he stated, "Now I don't sleep, I have dreams of Resident #2 coming in my room and standing over my bed smiling, and I cannot move or speak. I scream at him to get out of my room, but he just moves a couple steps . . . and I cannot move in my dream, I cannot get away from him. I think about his . . . being all over me and it makes me sick. I think his coming in my room all those times prior to the incident was him setting up to do what he did. This has been a terrible ordeal for me because I cannot see anything being done." Resident #1 stated, "when my case manager told

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A 165	Continued From page 41 me to call the police and report this, the Administrator heard I was going to do this and called the police before I could." Resident #1 stated he reported this incident to his case manager, and she reached out to the Administrator and told him this was being handled. Resident #1 stated, "I'm also worried that he may be doing this to someone else in the facility. It's just weird that he would pick me and do this to me. I believe he must have something in his past. I was assured that an incident report would be filed. I now lock my door and I am so scared he's coming in my room that I check the closet after I return to my room to make sure he's not in my room. Often my mind races trying to remember if I locked the door or turned on the light in order to keep him out and make sure I know he's out." Resident #1 reported he does not feel safe at the facility and feels that he is not being protected. He again stated that night staff do not come out of their bedroom during their shift. He stated there have been over 10 incidents of him in the hallway yelling about Resident #2 coming into his room. Resident #1 stated, "A detective came out on to investigate the allegation, but the detective basically told me that there was nothing they could do because it was my word against his (Resident #2)." Resident #1 reported that when the detective came to the facility, the Administrator was also at the facility. Resident #1 reported he pointed out the facility had video cameras to the detective, but the Administrator informed them both that he controlled the cameras and there was no footage since it had been over 30 days since the assault incident. According to Resident #1, the Administrator stated recordings are only available for 30 days.	A 165		

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A 165	Continued From page 42 On at 10:32 AM an interview was conducted with Resident #2, the alleged . Resident #2 revealed he had been living at the facility about a year. When the surveyor asked Resident #2 about the alleged assault to Resident #1, Resident #2 stated that he was "having a and does not remember what happened." He stated that he does not remember Resident #1 approaching him and asking him anything about the incident. Resident #2 stated that no staff had talked with him about the incident that he could remember. He also stated he does not have any memory issues. On at 10:36 AM, an interview was conducted with Staff B, lead staff and caretaker, who reported that Resident #1 informed her the day after the incident that Resident #2 had come into his room and tried to on him. Staff B stated Resident #1 told her that he screamed, and nobody came to check on him. She also reported that Resident #1 said he told Resident #2 to get out of his room and he did. Staff B stated she told Resident #1 that he needed to inform the Administrator of the incident. Staff B stated to the surveyor that she did not do anything, instead "stayed out of it and allowed Resident #1 to report the incident himself to the Administrator." She also confirmed that no one at the facility called the police to her knowledge although the police came out the other day ( ) to investigate. Staff B reported Resident #1 and the Administrator were involved in the meeting with the officer. She stated that staff have received training on , neglect, and . She also stated she has "worked the overnight shift on occasion and staff are allowed to sleep at night due to there not being that many residents." She stated, "about 12 AM	A 165		

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A 165	Continued From page 43 staff will go lay down in the staff bedroom, which is the room located directly across from Resident #1's room." On . . . . . at 10:43AM and on at 12:30PM, telephone interviews were conducted with Staff C, a caretaker who reported that she was not at the facility the night of the incident between Resident #1 and Resident #2. She advised she worked on the weekend. She stated Resident #1 told her when she got there on the weekend for her shift but could not recall what the exact date was that the incident had occurred. She stated Resident #1 reported the incident to her several days after the incident happened. She stated that Resident #1 reported to her that Resident #2 came into his bedroom (Resident #1) and tried to , assault him. Staff C states she passed the information along to the Administrator who owns the facility. She also stated she believes the Administrator was working that night. She again confirmed that she had reported the incident immediately to the Administrator. Staff C was unable to provide an exact date that Resident #1 had reported the incident to her. On at 11:20 AM, a telephone interview was conducted with the case manager for Resident #1. The case manager stated she was informed of the incident on . . . when the resident contacted her about it. She stated Resident #1 said he was in bed and woke up with a resident on him trying to , assault him. On . . . . . after receiving the complaint, she contacted her supervisor who contacted the police and Adult Protective Services because no one from the facility had reported this incident to any authorities. The case manager reported the detective stated he would be coming to the facility	A 165		

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A 165	Continued From page 44 on . . . . . to speak to Resident #1 but did not go until . She stated Resident #1 informed her that he did not feel safe and wanted out of the facility. She also reported she advised Resident #1 to report the incident to the Agency for Health Care Administration's Complaint Unit based on advice from her supervisor. The case manager stated, "I've been trying to find another placement for him. I emailed him a list of apartments in the area. I also offered another assisted living facility (ALF) in the area, but he's fearful of living in an ALF since this incident." The case manager stated, "I've been with [name of agency] for 9 years and this is mind boggling. He's been so . . . . I cannot believe how the Administrator is acting like this is nothing." On at 12:55 PM, a telephone interview was conducted with the Administrator who reported he had not received any grievances from any residents or filed any adverse incident reports. The Administrator stated that when the incident was brought to his attention he talked with both residents and, "it was a case of he said, he said." The Administrator stated that he did not conduct a formal investigation of the allegations or review any video because the cameras do not show what happens in the resident's room. On at 9:30 AM, a telephone interview was conducted with Staff D who reported she had only worked at the facility for a couple months. Staff D stated she was not at the facility at the time the incident occurred but confirmed Resident #1 and Resident #2 got into an altercation about the incident. She stated she asked Resident #2 about the incident involving Resident #1 and, "he admitted to doing that to Resident #1." Staff D stated she went over the rules about touching people with Resident #2 and he expressed regret	A 165		

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A 165	Continued From page 45 about it. Staff D stated she was at the facility working on the day that law enforcement arrived to investigate but was never asked about the incident. When asked how she supervises the residents while working the night shift, she stated she "can keep an , on them overnight on the cameras from the staff bedroom" but stated she had not seen Resident #2 enter Resident #1's room. On at 3:48 PM, a follow-up telephone interview was conducted with the Administrator. When asked about the process for reviewing cameras, he stated, "I use the cameras so I can see what is going on in the facility from a distance through my telephone. I have cameras in the facility, there is a camera in the main hall facing the bathroom so I can see the two resident doors, but not inside the resident rooms. There is one in the office, one in the main front area, laundry room and pantry area in the kitchen." When asked how long the footage is accessible, he stated, "it records over itself every 30 days to save drive space so there is no footage from the day of the incident which took place in ." When asked who had access and if staff are supposed to be monitoring the cameras, he stated "staff can monitor the cameras overnight and they are allowed to sleep at night since we only have 5 residents." When asked about when the incident occurred and when Resident #1 reported this, the Administrator stated, "Resident #1 reported this about seven days later after the incident. He told Staff C and informed her of what happened." The Administrator stated he believed Resident #1 "was just trying to get Resident #2 kicked out of the facility. He's had problems with every roommate he's ever had." When asked if he had any documentation to confirm Resident #1 had	A 165		

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A 165	Continued From page 46 the behavior issues he was describing, or was known for reporting false allegations, the Administrator admitted he did not. He also stated he did not report the incident because Resident #1 did not want to report it. On . . . . . at 4:13 PM, a telephone interview was conducted with the responding Law Enforcement Officer (LEO). The LEO stated "it took several days for Resident #1 to report the assault. He did not report it initially, because he thought the offending resident would be discharged from the facility but decided to contact law enforcement after he figured out that Resident #2 was not going to be discharged from the facility." The LEO stated he took the initial report, "then it goes to detectives to be followed up on." He also was not sure which detective would be assigned the case, but it would be someone in violent crimes unit. The LEO stated, "staff confirmed with him that Resident #2 creeps around the house at night" and he attempted to contact the staff person who was onsite (Staff D) but was unable to reach. The LEO reported Resident #1 stated he was screaming out so he cannot understand how staff could not hear the resident yelling out. The LEO added, "The facility did not put a lock on Resident #1's door until after Resident #2 again came into Resident #1's room in an incident after the assault incident." A review of Resident #1 and Resident #2's records revealed there were no records or documentation related to the above incidents. Resident health records contained the resident health assessment (form 1823), list of medications, insurance information, etc. However, the records contained only blank "resident observation forms".	A 165		

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A 165	Continued From page 47 A review of the Agency's Adverse Incident Reporting System on revealed there were no adverse incident reports on file for this facility. The policy and procedure for reporting adverse incidents was requested but the facility was unable to provide one. A review of the facility's undated policy Reporting of Neglect & , revealed: "All staff, residents, guests and government agencies alike are to report any resident's rights being violated." Procedure: 1. The number to report , neglect & , is 1.800.96. . 2. Immediately contact the administrator or manager of incident. 3. Follow-up with Department of Children and Families as to the outcome of the report. Class II	A 165		
CZ815 SS=C	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 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.	CZ815		

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CZ815	Continued From page 48 (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. (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:	CZ815		

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CZ815	Continued From page 49 (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 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.	CZ815		

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CZ815	Continued From page 50 (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. (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	CZ815		

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CZ815	Continued From page 51	CZ815		

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 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

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CZ815	Continued From page 52 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 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	CZ815		

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CZ815	Continued From page 53 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. 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 record review and interview, the facility failed to ensure that 1 of 5 employees (Staff D) had an eligible level 2 background screening.	CZ815		

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CZ815	Continued From page 54 The findings include: On . . . . , a record review was conducted of five employees' personnel files for eligible level 2 background screenings. The level 2 located in Staff D's personnel record indicated that the status of the employee's eligibility was, "screening in process" with a screening date of . On at approximately 11:30 AM, an interview was conducted with Staff B, lead staff and caretaker. Staff B reviewed Staff D's personnel record and confirmed that the level 2 background screening located in the employee's record indicated an eligibility status of "screening in process". Staff B reported that the Administrator oversees the background screening and employee personnel records. On at 12:15 PM, a telephone interview was conducted with a Health Services & Facilities Consultant and the Supervisor in the Agency for Health Care Administration's Background Screening Unit who indicated that Staff D was ineligible as the unit was still processing the background screening. The background screening staff clarified that Staff D was not considered eligible to work. The Supervisor for the Background Screening Unit indicated that a "provisional start date" only means that an employee can start training or orientation, but that the employee is not permitted to work with residents until an "eligible" status is indicated. On . . . . . at approximately 12:37 PM, a telephone interview was conducted with the Administrator who reported that when he input Staff D's information into the Clearinghouse for Background Screening website, the employee was given a "provisional start date" and could	CZ815		

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CZ815	Continued From page 55 work under this status. The Administrator was unable to inform surveyors what a "provisional start date" meant. The Administrator was informed that per the Background Screening Unit, the employee was not eligible to work until the screening process had been conducted and the employee had an "eligible" status. Review of a timesheet dated [redacted] revealed Staff D worked at the facility on the following dates: 3:00 PM - 8:00 PM [redacted] 3:55 PM - 8:00 PM 3:00 PM - 8:00 PM [redacted] 6:50 AM - 3:00 PM 6:50 AM - 3:00 PM [redacted] 3:00 PM - 8:00 PM 3:00 PM - 8:00 PM [redacted] 7:40 PM- [redacted] 8:15 AM 7:55 PM. The time the employee ended her shift was not indicated. 3:00 PM - 8:00 PM [redacted] 3:00 PM - 8:00 PM 3:00 PM - 8:00PM [redacted] 3:00 PM - 8:00 PM Unclassified	CZ815		
CZ816 SS=C	408.809(2) 435.05(2) 59A-35.090(2d-3b) Background Screening-Compliance Attestation 408.809 Background screening; prohibited offenses.- (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such	CZ816		

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CZ816	Continued From page 56 license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's [illegible], to the Federal Bureau of Investigation for a national criminal history record check unless the person's [illegible] are enrolled in the Federal Bureau of Investigation's national retained print [illegible] notification program. If the [illegible] of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit [illegible] electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the [illegible] to the Federal Bureau of Investigation for a national criminal history record check. The [illegible] shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print [illegible] notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person [illegible]. The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that: (a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section;	CZ816		

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CZ816	Continued From page 57 (b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and (c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency. 435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers: (2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if . . . . . for any of the disqualifying offenses while employed by the employer. 59A-35.090 Background Screening. (2) Processing Screening Requests, Required Documents and Fees. (d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, ... , herein incorporated by reference, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-09106, and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Regulations_Forms.shtml. This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if for any disqualifying offense.	CZ816		

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CZ816	Continued From page 58 (e) An administrator or chief financial officer must be screened and qualified prior to , , to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the . . . report and court disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to Section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with Section 435.06(3), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that 1 of 5 employees (Staff C) completed an Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008 and retain the form in the employee's personnel record. The findings include: On , a record review was conducted of Staff C's personnel record. The attestation form located in Staff C's personnel record was found to be without a signature or date.	CZ816		

Agency for Health Care Administration

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CZ816	Continued From page 59 On ..... at approximately 11:30 AM, Staff B, lead staff and caretaker, reviewed Staff C's personnel record and confirmed that the attestation was not signed and dated. During a subsequent interview, Staff B reported that the Administrator oversees the background screenings and attestation with compliance for background screening in employees' personnel records. On ..... at approximately 12:37 PM, a telephone interview with the Administrator was conducted and he reported he could not explain why Staff C's attestation of compliance with background screening form was not signed and dated. Unclassified	CZ816		