

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967421	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/10/2022
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY-KISSIMMEE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1471 SUNGATE DRIVE KISSIMMEE, FL 34746		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments A third revisit to the re-licensure survey was conducted at Good Samaritan Society-Kissimmee Village on . Deficiencies were identified at the time of survey.	{A 000}		
{A 091} SS=D	59A-36.011(12) FAC Training - Documentation & Monitoring (12) TRAINING DOCUMENTATION AND MONITORING. (a) Except as otherwise noted, certificates, or copies of certificates, of any training required by this rule must be documented in the facility's personnel files. The documentation must include the following: 1. The title of the training program, 2. The subject matter of the training program, 3. The training program agenda, 4. The number of hours of the training program, 5. The trainee's name, dates of participation, and location of the training program, 6. The training provider's name, dated signature and credentials, and professional license number, if applicable. (b) Upon successful completion of training pursuant to this rule, the training provider must issue a certificate to the trainee as specified in this rule. (c) The facility must provide the Department of Elder Affairs and the Agency for Health Care Administration with training documentation and training certificates for review, as requested. The department and agency reserve the right to attend and monitor all facility in-service training, which is intended to meet regulatory requirements. This Statute or Rule is not met as evidenced by: DEFICIENCY REMAINED UNCORRECTED	{A 091}		

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967421	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/10/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GOOD SAMARITAN SOCIETY-KISSIMMEE VILLAGE

**1471 SUNGATE DRIVE
KISSIMMEE, FL 34746**

(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 091}	Continued From page 1 Based on personnel record review and interview, the facility failed to ensure that all training certificates met the requirements as specified in 59A-36.011(12) FAC for 2 of 2 sampled staff (C and E). Findings: Review of the plan of correction dated submitted by the facility to the Agency revealed certificates on training for staff C and E. 1. Staff A - had the following certificates were all dated " - " a 1- hour control in-service a 1- hour recognizing and neglect in-service a 1- hour emergency procedures/evaluation in-service a 1- hour major incident reporting a 1- hour resident's rights a 1-hour elopement in-service and a 1- hour in-service training a 2-hour regarding 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. The review revealed the certificates did not contain the dated signature of the trainer. 2. Staff E - had the following certificates were all dated " - /202" a 1- hour control in-service a 1- hour recognizing and neglect in-service. a 1- hour emergency procedures a 1- hour major incident reporting. a 1- hour elopement in-service and a 1- hour in-service training	{A 091}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967421	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/10/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GOOD SAMARITAN SOCIETY-KISSIMMEE VILLAGE

**1471 SUNGATE DRIVE
KISSIMMEE, FL 34746**

(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 091}	Continued From page 2 a 2-hour regarding 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. The review revealed the certificates did not contain the dated signature of the trainer. The certificates were reviewed with the administrator on at 11:15 AM who confirmed the findings. Class III	{A 091}		
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic submission to the Department of Law Enforcement. The registration must include the employee's full first	CZ814		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967421	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/10/2022
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY-KISSIMMEE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1471 SUNGATE DRIVE KISSIMMEE, FL 34746		
(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
CZ814	Continued From page 3 name, middle initial, and last name; social security number; date of birth; mailing address; ...; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: DEFICIENCY REMAINED UNCORRECTED Based on record review and interview the facility failed to maintain the employment status of all employees within the background screening (BGS) clearinghouse. Findings: Review of the plan of correction dated submitted by the facility to the Agency indicated that staff A and D no longer were employed by the facility. In an interview with the administrator on at 10:15 AM who confirmed the above. She stated staff A was not employed effective and staff D effective Review of the facility BGS roster on at 12:30 PM revealed staff A and D were listed as current facility employees. The BGS roster was reviewed with the administrator on at 11 AM who said she needed to update the roster.	CZ814		