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 |
|---|---|---|---|
| | AL11969549 | A. BUILDING: _____ B. WING _____ | 01/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| S & M ASSISTED LIVING FACILITY LLC | 9950 NW 24TH AVE MIAMI, FL 33147 |

| (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 |
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| A 000 | Initial Comments<br><br>A complaint investigation (complaint number 2022000902) was conducted at S & M Assisted Living Facility, LLC on , , to . . . . . Deficiencies were identified at the time of survey. | A 000 | | |
| A 025 SS=G | 429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision<br><br>429.26<br>(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 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.<br><br>59A-36.007 Resident Care Standards.<br>An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.<br>(1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following:<br>(a) Monitoring of the quantity and quality of | A 025 | | |

AHCA Form 3020-0001

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

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| A 025 | Continued From page 1<br><br>resident diets in accordance with Rule 59A-36.012, F.A.C.<br>(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.<br>(c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.<br>(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.<br>(e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.<br>(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.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to maintain a general awareness of the whereabouts of one out of six sampled residents (Resident #1). Resident #1 tried to elope from the facility on [redacted], to a hospital and returned to the facility [redacted]. The facility did not put any elopement precautions in place, to avoid a repeated occurrence. On [redacted], Resident #1 eloped from the facility during the night and two days later, he showed up at a hospital emergency room.<br><br>Findings included: | A 025 | | |

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| A 025 | Continued From page 2<br><br>A review of the Agency Incident Report System showed Resident # 1 eloped from the facility during the early hours on [redacted], and the staff did not know the resident whereabouts at the time. On [redacted], he was found at the emergency room.<br><br>Review of Resident 1's record showed an admission date of [redacted], with a health assessment dated showed resident had a diagnosis of [redacted], with universal precautions, and no elopement risks. The resident was Independent with all activities of daily living, and needed supervision with bathing, and assistance when eating. The resident had a regular diet and needed assistance with self-administration of medications.<br><br>Further review of Resident #1 record showed progress notes dated stating "I went around to search for the patient for most of the day, and then I called the [nearby local hospitals] to check for the patient." On [redacted] the note showed "I called [a local hospital] today at 4:48 PM, the operator on the phone let me know they discharged him from the hospital at 4:43 AM, but he didn't come home. I called the social worker and his nurse again. I also contacted the police to let them know what I found out, and they let me know that he is still considered a missing person until he gets home."<br><br>On [redacted], at 10:25 AM, the Owner stated, "I was not here that night [redacted], I had an emergency, she [Staff C] was by herself; I called the administrator, and she went to look for resident. I called the police when I got here but they did not find him. On the I called [a local hospital], he was there and was discharged; they did not notify us. I spoke to | A 025 | | |

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| A 025 | Continued From page 3<br><br>the nurse who was taking care of him, and she told me he was discharged at 4:43 AM on [redacted], he refused treatment. I don't understand why they did not notify us."<br><br>Review of Resident #1 hospital record showed, the resident arrived at the emergency department on [redacted] for [redacted], [redacted] non [redacted]. Further review of the hospital record showed he was discharged from the emergency room on [redacted], but not [redacted] to the assisted living facility. He was discharge to a person listed as a friend.<br><br>On [redacted], at 11:31 AM, the Owner stated resident tried to leave the facility on another occasion. She stated, "On [redacted], around 4:30 PM, I opened the gate to get my car out, and he went to the sidewalk; when I asked him to get inside, he got furious and said, "Don't touch me." Then, I called the police; he started walking, and I followed him, when the police came, we were about few blocks from here. When they got there, he was calmed and got to the police car, and returned to the facility. After that, I sent him to the hospital, he was there for 15 days, he came [redacted] on the 13th."<br><br>Review of Resident #1 hospital's record showed the resident was [redacted] by the local authorities on [redacted] at 5:52 PM after informing ALF caretaker that he was [redacted] that told him to walk into traffic. The hospital record showed, the resident was admitted to the hospital [redacted] unit on [redacted] with diagnosis of [redacted]. He was discharge [redacted] to the facility on [redacted].<br><br>On [redacted], at 1:45 PM, Staff C stated, on [redacted], "I was here all night; before | A 025 | | |

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| A 025 | Continued From page 4<br><br>he [Resident #1] went to his room, he asked me for a cigarette, and I gave it to him. He was outside around 9:00 PM, at 10:00 PM, I checked him, and he was sleepy, and asked him to go to his room, I closed the doors at 10:30 or 11:00 PM, then I went to sleep. I do not remember what time it was when I didn't see him, but it was not daylight yet. I looked everywhere; I went to the main avenue in the dark, I called the owner and she met me there."<br><br>On , , at 9:50 AM during a phone interview with the resident's program staff, she stated, "We are aware of what happened in , he said that he [Resident #1] did not want to stay there [ALF] any more, that he wanted to go home. He was asking the owner for money to leave. He was not sleeping at all; he would stay up all night."<br><br>Review of the facility's elopement policy and procedures dated 2018, showed,<br>'Each resident shall have an 1823 health assessment that reflects if the resident is an elopement risk.<br>Administrator is to have a new health assessment conducted for any resident that pose a risk of eloping. '<br><br>Review of Resident #1 record showed he attempted to elope from the facility on , law enforcement was notified, the resident was to the hospital, and remained for approximately 15 days.<br><br>Further review of Resident #1 record showed the resident was readmitted to the facility on and there was no updated 1823 AHCA health assessment and no documentation the facility put any elopement precautions in | A 025 | | |

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| A 025 | Continued From page 5<br>place, to avoid a repeated occurrence.<br><br>Class II | A 025 | | |
| A 032 SS=D | 59A-36.007(7) FAC Resident Care - Elopement Standards<br><br>59A-36.007<br>(7) ELOPEMENT STANDARDS.<br>(a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days.<br>1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times.<br>2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. | A 032 | | |

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| A 032 | Continued From page 6<br><br>The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative.<br>(b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for:<br>1. An immediate search of the facility and premises,<br>2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities,<br>3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and,<br>4. The continued care of all residents within the facility in the event of an elopement.<br>(c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to follow its policy and procedures regarding elopement for one out of six residents (resident #1). The facility failed to reassess the resident after he attempted to elope from the facility in [redacted] and [redacted] to a hospital and readmitted to the facility [redacted]. | A 032 | | |

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| A 032 | Continued From page 7<br><br>Findings included:<br><br>Review of Resident 1's record showed an admission date of [redacted], with a health assessment dated [redacted] that showed resident had a diagnosis of [redacted], with universal precautions, and no elopement risks. The resident was Independent with all activities of daily living, and needed supervision with bathing, and assistance when eating. The resident had a regular diet and needed assistance with self-administration of medications.<br><br>On [redacted], at 11:31 AM, the Owner stated, "On [redacted], around 4:30 PM, I opened the gate to get my car out, and he went to the sidewalk; when I asked him to get inside, he got furious and said, "Don't touch me." Then, I called the police; he started walking, and I followed him, when the police came, we were about few blocks from here. When they got there, he was calmed and got to the police car, and returned to the facility. After that, I sent him to the hospital, he was there for 15 days, he came on the 13th."<br><br>Review of Resident #1 hospital's record showed the resident was [redacted] by the local authorities on [redacted] at 5:52 PM after informing ALF caretaker that he was [redacted] that told him to walk into traffic. The hospital record showed, the resident was admitted to the hospital [redacted] unit on [redacted] with diagnosis of [redacted]. He was discharge [redacted] to the facility on [redacted].<br><br>Review of the facility's elopement policy and procedures dated 2018 showed,<br>'Each resident shall have an 1823 health assessment that reflects if the resident is an | A 032 | | |

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| A 032 | Continued From page 8<br><br>elopement risk.'<br>'Administrator is to have a new health assessment conducted for any resident that pose a risk of eloping. '<br><br>Review of the Resident #1 records showed no documentation a new health assessment was completed after resident tried to elope from the facility on [redacted] to a hospital and readmitted to the facility [redacted].<br><br>Class III | A 032 | | |
| A 079 SS=D | 59A-36.010(3) FAC Staffing Standards - Levels<br><br>(3) STAFFING STANDARDS.<br>(a) Minimum staffing:<br>1. Facilities must maintain the following minimum staff hours per week:<br><br>Number of Residents, Day Care Participants, and Respite Care Residents — Staff Hours/Week<br>0-5 — 168<br>— 212<br>16-25 — 253<br>26-35 — 294<br>36-45 — 335<br>46-55 — 375<br>56-65 — 416<br>66-75 — 457<br>76-85 — 498<br>86-95 — 539<br><br>For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week.<br>2. Independent living residents, as referenced in | A 079 | | |

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| A 079 | Continued From page 9<br>subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours.<br>3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility.<br>4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night.<br>5. A staff member who has completed courses in First Aid and [illegible] ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times.<br>a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement.<br>b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and .<br>6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least [illegible] must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a | A 079 | | |

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| A 079 | Continued From page 10 | A 079 | | |

calendar year, without being an administrator or manager.
7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement.
8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule.
9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted.
(b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C.
(c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives.
(d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision

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| A 079 | Continued From page 11<br>and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met.<br>1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs.<br>2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency.<br>(e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios.<br>(f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, | A 079 | | |

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| A 079 | Continued From page 12<br><br>59A-36.021 or 59A-36.022, F.A.C., respectively.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to maintain written staffing hours per week.<br><br>Findings included:<br><br>Review of the facility's staff schedule for the month of [redacted], showed no written specific times/hours the staff was scheduled to work. Review of the staff schedule showed an X or O in a box under the dates. (Photographic evidence attach)<br><br>On [redacted] at 2:45PM, The administrator acknowledged the staff scheduled did not have the times/hours listed.<br><br>Class III | A 079 | | |
| A 081 SS=D | 429.52(1 & 7) FS; 59A-36.011([redacted]) FAC Training - Staff In-Service<br><br>429.52(1)<br>(1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. | A 081 | | |

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| | AL11969549 | A. BUILDING: _____ B. WING _____ | 01/28/2022 |

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| A 081 | Continued From page 13<br><br>(7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course.<br><br>59A-36.011<br>(2) STAFF PRESERVICE ORIENTATION.<br>(a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1).<br>(b) New staff must complete the preservice orientation prior to interacting with residents.<br>(c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record.<br>(d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover:<br>1. Resident's rights; and,<br>2. The facility's license type and services offered by the facility.<br>(3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff:<br>(a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 | A 081 | | |

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| A 081 | Continued From page 14<br>hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , may be used to meet this requirement.<br>(b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects:<br>1. Reporting adverse incidents.<br>2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation.<br>(c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects:<br>1. Resident rights in an assisted living facility.<br>2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training.<br>(d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects:<br>1. Resident behavior and needs.<br>2. Providing assistance with the activities of daily living.<br>(e) Staff who prepare or serve food, who have not taken the assisted living facility core training must | A 081 | | |

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| A 081 | Continued From page 15<br>receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices.<br>(f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment.<br>1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures.<br>2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure staff that provide direct care to residents receive the in-service trainings relevant to their job duties as specified by agency rule for two out of three sampled staff (Staff B and C).<br><br>Findings included:<br><br>Review of Staff B's personnel record showed a hired date of [redacted]. There was no documentation of completed trainings within 30 days of employment in reporting adverse incidents, facility emergency procedures, resident rights in an assisted living facility, recognizing and reporting resident [redacted], neglect and [redacted], safe food handling practices and resident elopement response policies and procedures in file.<br><br>Review of Staff C's personnel record showed a hired date of [redacted]. There was no | A 081 | | |

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| A 081 | Continued From page 16<br><br>documentation of completed trainings within 30 days of employment in reporting adverse incidents, facility emergency procedures, resident rights in an assisted living facility, recognizing and reporting resident , neglect and , safe food handling practices and resident elopement response policies and procedures in file.<br><br>On at 3:00 PM, the Administrator stated, "Those are all the trainings our consultant gave us, I thought those were all the trainings we needed."<br><br>Class III | A 081 | | |
| AL243 SS=D | 429.075(1) FS; 59A-36.011(9) FAC LMH - Training<br><br>429.075<br>(1) To obtain a limited mental health license, a facility must hold a standard license as an assisted living facility, must not have any current uncorrected violations, and must ensure that, within 6 months after receiving a limited mental health license, the facility administrator and the staff of the facility who are in direct contact with mental health residents must complete training of no less than 6 hours related to their duties. This designation may be made at the time of initial licensure or relicensure or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with this part, part II of chapter 408, and applicable rules. This training must be provided by or approved by the Department of Children and Families.<br><br>59A-36.011 | AL243 | | |

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| AL243 | Continued From page 17<br><br>(9) LIMITED MENTAL HEALTH TRAINING.<br>(a) Pursuant to section 429.075, F.S., the administrator, managers and staff, who have direct contact with mental health residents in a licensed limited mental health facility, must receive the following training:<br>1. A minimum of 6 hours of specialized training in working with individuals with mental health diagnoses.<br>a. The training must be provided or approved by the Department of Children and Families and must be taken within 6 months of the facility's receiving a limited mental health license or within 6 months of employment in a limited mental health facility.<br>b. Training received under this subparagraph may count once for 6 of the 12 hours of continuing education required for administrators and managers pursuant to section 429.52(5), F.S., and subsection (1) of this rule.<br>2. A minimum of 3 hours of continuing education, which may be provided by the ALF administrator, online, or through distance learning, biennially thereafter in subjects dealing with one or more of the following topics:<br>a. Mental health diagnoses; and,<br>b. Mental health treatment such as:<br>(I) Mental health needs, services, behaviors and appropriate interventions;<br>(II) Resident progress in achieving treatment goals;<br>(III) How to recognize changes in the resident's status or condition that may affect other services received or may require intervention; and,<br>( ) Crisis services and the . . . . . procedures.<br>3. For administrators and managers, the continuing education requirement under this subsection will satisfy 3 of the 12 hours of | AL243 | | |

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| AL243 | Continued From page 18<br><br>continuing education required biennially pursuant to section 429.52(5), F.S., and subsection (1) of this rule.<br>4. Administrators, managers and direct contact staff affected by the continuing education requirement under this subsection shall have up to 6 months after the effective date of this rule to meet the training requirement.<br>(b) Administrators, managers and staff do not have to repeat the initial training should they change employers provided they present a copy of their training certificate to the current employer for retention in the facility's personnel files. They must also ensure that copies of the continuing education training certificates, pursuant to subparagraph (a)2. of this subsection, are retained in their personnel files.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview, the facility hold a limited mental health license and failed to ensure staff of the facility who are in direct contact with mental health residents complete training of a minimum of 6 hours of specialized training in working with individuals with mental health diagnosis for two out of three sampled staff (Staff A and C) and a minimum of 3 hours of continuing education biennially for one out of three sampled staff (Staff B).<br><br>Findings included:<br><br>Review of Staff A personnel records showed a hired date of [redacted]. There was no documentation the staff completed 6 hours of specialized training in working with individuals with mental health diagnosis in file.<br><br>Review of Staff C personnel records showed a | AL243 | | |

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| AL243 | Continued From page 19<br><br>hired date of . . . . . . . . There was no documentation the staff completed 6 hours of specialized training in working with individuals with mental health diagnosis in file.<br><br>Review of Staff B's personnel record showed a hired date of . . . . . . . . There was no documentation staff completed the 3 hours of continuing education in mental health trainings in file.<br><br>On , . at 3:00 PM, the Administrator stated, " I thought those were all the trainings we needed."<br><br>Class III | AL243 | | |